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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

Fraud in Ch

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for
September 6, 1983

VOLUME 28

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2 DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

3

4

5 Hearing held on the 8th Floor,
6 180 Dundas Street West, Toronto,
7 Ontario, on Tuesday, the 6th
8 day of September, 1983.
9

10 -----
11

12 THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
13 THOMAS MILLAR - Administrator
14 MURRAY R. ELLIOT - Registrar
15

16 -----
17

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(Cont'd)



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& Mrs. Lutes and Mr. & Mrs.
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Jordan Hines)
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12 J. SHINEHOFT Counsel for Lorie Pacsai and
Kevin Garnet (parents of
deceased child Kevin Pacsai)
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/ET/ak

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---Upon commencing at 10:00 a.m.

3

THE COMMISSIONER: Yes, Miss Cronk?

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6

MS. CRONK: Mr. Commissioner, our next witness is Dr. Robert Freedom from the Hospital for Sick Children.

7

Dr. Freedom.

8

DR. ROBERT MARK FREEDOM, Sworn

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DIRECT EXAMINATION BY MS. CRONK:

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Q. Dr. Freedom, as you know we have heard lengthy evidence in the last several weeks concerning 36 children in respect of whose deaths this Commission is interested. I do not intend to go through with you in detail the many events that happened during the hospitalization of those children save where you appear on the face of the medical record to have had some direct involvement in their care and their management.

Perhaps if we could start, Dr. Freedom, with your curriculum vitae which you have been kind enough to provide to me through counsel.

THE COMMISSIONER: No. 167.

---EXHIBIT NO. 167: Curriculum Vitae of Dr. Robert Mark Freedom.

MS. CRONK: Q. Dr. Freedom, as I understand it you are presently 42 years of age and



1

2 a Professor of Pediatrics Cardiology at the Hospital
3 for Sick Children and at the University of Toronto.

4 Is that correct?

5 A. Yes, it is.

6 Q. You are as well Professor of
7 Pathology both at the Hospital and the University of
8 Toronto?

9 A. Correct.

10 Q. You obtained your medical
11 degree at UCLA in 1968 and then did an internship
12 and residency in Pediatrics at the Children's
13 Hospital Medical Centre in Boston from 1968 till 1970.

14 A. Right.

15 Q. You spent the next two years
16 as I understand it, Dr. Freedom, doing fellowship in
17 Pediatric Cardiology at the same hospital?

18 A. Correct.

19 Q. Can you help me, Dr. Freedom,
20 as to when you joined the staff of the Hospital for
21 Sick Children in Toronto?

22 A. In the summer of 1974.

23 Q. In what capacity did you then
24 join the staff?

25 A. I was I believe either
Assistant or Associate Professor of Pediatrics and
Pathology.



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Q. And you are now, as I understand it, Dr. Freedom, a staff cardiologist and a full professor of Pediatrics Cardiology and Pathology at the Hospital?

A. Correct.

Q. You are a member, Dr. Freedom, looking at your curriculum vitae, of a great number of professional societies, editorial boards; you are as well an author of numerous abstracts, papers, book chapters both in the field of pediatrics cardiology and in the area of diagnostic techniques as the same relate to pediatrics cardiology; is that correct, sir?

A. Correct.

Q. And indeed as I note from your curriculum vitae you co-authored a book with Dr. Rowe, amongst others, entitled, "Neonatal Congenital Heart Disease".

A. Correct.

Q. In your capacity as staff cardiologist at the Hospital, Doctor, as I understand it, in light of the system employed in the cardiology wards, you served on occasion both as ward chief of the ward and in addition to your daily duties are on occasion staff cardiologist on call at night?



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2

A. Correct.

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5

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Q. And you have told us, sir,
you are as well a Professor of Pathology. As I
understand you hold a cross appointment in pathology
at the Hospital?

7

A. Correct.

8

9

10

Q. Can you assist me, Dr. Freedom,
by virtue of that cross appointment, what duties or
responsibilities if any do you have in the Department
of Pathology at the Hospital?

11

12

13

A. My primary role in the

Department of Pathology is to serve them as a cardiac
anatomist and morphologist.

14

15

16

Q. Can you help me further,
Dr. Freedom, as to the manner in which you do serve
them in that capacity?

17

18

19

20

A. I will be called by the
Department of Pathology when a youngster with
congenital heart disease has died, and they will ask
me to help them in the dissection and description of
the cardiac anatomy.

21

22

23

Q. Do you actually participate
in the autopsy itself, Doctor? Do you dissect the
heart?

24

25

A. I will often dissect the heart



1

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either by myself or directing one of the pediatric
residents to do so.

3

4

Q. Right. And in the course of
an autopsy again on a pediatric cardiology patient,
do members of the Pathology Department actively
participate as well in the conduct of the autopsy?

5

6

7

A. They direct the autopsy and
I serve them primarily as a consultant with reference
to the heart.

8

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Q. Right. Now in respect again
of that cross appointment and your involvement with
the Department of Pathology, Doctor, what are your
additional responsibilities and duties if any to the
Cardiology Division, other than those you would have
as staff cardiologist?

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A. Perhaps the primary function
beyond that as a clinical cardiologist is to provide
on an ongoing basis the results of the cardiac
autopsies to the work conference that we have every
morning at 8:30, Monday to Friday, and to work with
my liaison in the Department of Pathology with a
Monday afternoon conference devoted to the patients
with congenital heart disease.

Q. Now you have mentioned two
conferences, Doctor. The first as I understood it



1

2

when you referred to the morning conference, the
morning cardiology conference held every day on the
wards.

3

A. Yes.

4

Q. And the second, every Monday
afternoon? Is that a conference in the Pathology
Department or again a conference in the Cardiology
Division?

5

A. In the Department of Pathology.

6

Q. So that you attend, as I
understand it, both the weekly pathology conferences,
and in addition the morning cardiology conferences on
the cardiology ward?

7

A. Correct.

8

Q. Now you have indicated,

9

Dr. Freedom, that part of your role in participating
at those conferences is to report upon the autopsy
results.

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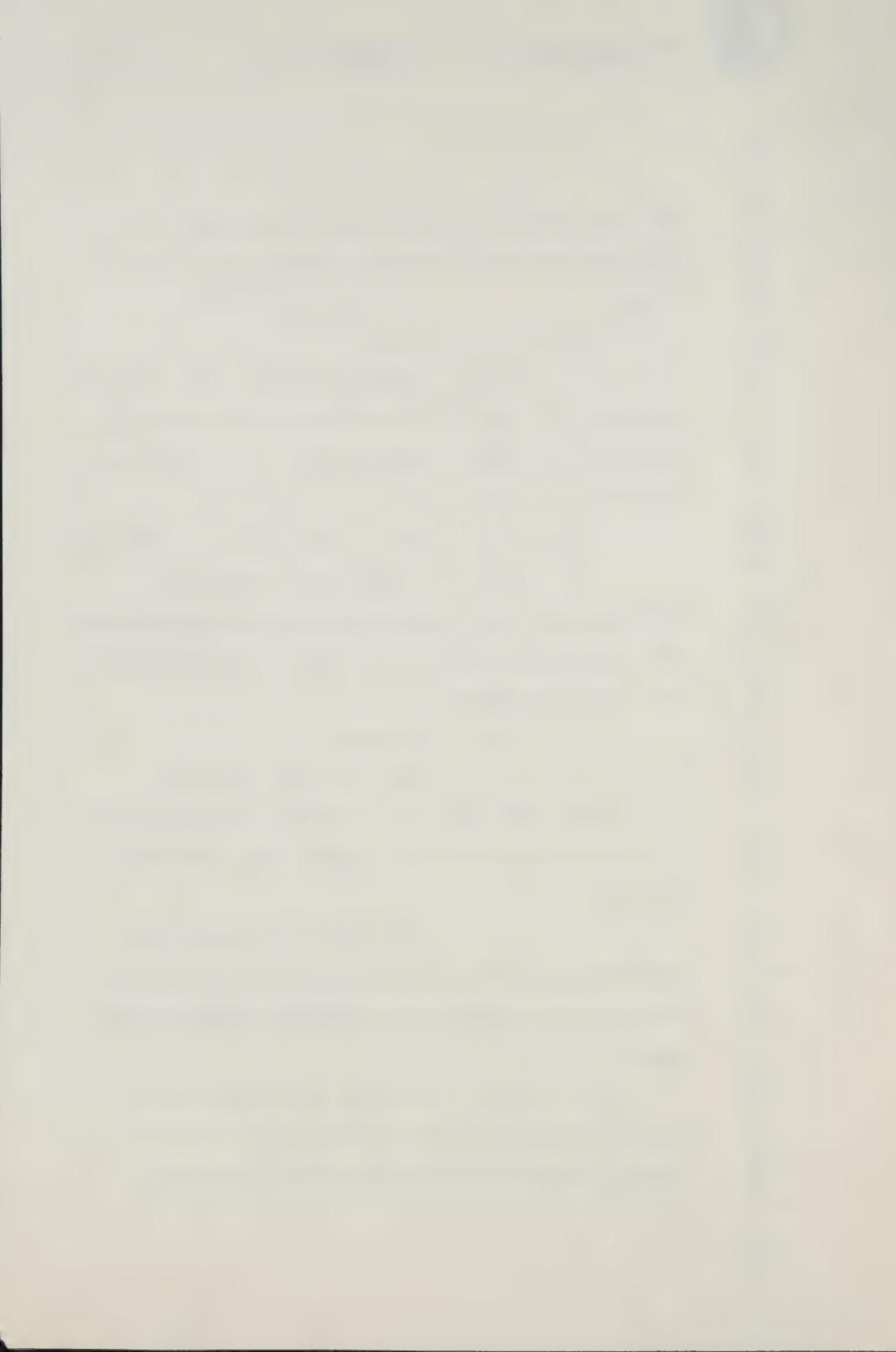
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Are you referring in that
regard to the gross autopsy results that would be
obtained on any particular cardiology patient after
death?

A. I think the primary point of
view is directed to the cardiac anatomy, and of
course if there are pertinent gross findings at





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autopsy, I will comment on those as well.

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Q. And subsequently, Dr. Freedom,

when the full and complete autopsy is performed I take it often on the same day, do you stay and observe the entire autopsy or only that part of the autopsy that pertains to the cardiac anatomy?

8

A. Only that pertaining to the cardiac anatomy.

9

10

11

12

13

Q. And in the course of your

tenure at the Hospital for Sick Children, would I be correct in assuming that you have seen literally hundreds of hearts from cardiac pediatric patients at autopsy?

14

A. Correct.

15

Q. In the normal course,

16

Dr. Freedom, would you obtain from the Pathology Department once it was available a copy of the preliminary autopsy report?

18

19

A. I would say in at least 50 to 60% one would cross my desk.

20

Q. Is that done automatically,

21

Dr. Freedom, or --

22

A. No.

23

Q. -- or is it a situation where you would request it?

24

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A. I would have to request it.

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Q. Right. And similarly we have heard evidence at the Commission to date that it is some considerable time after the preparation of a preliminary autopsy report that the final autopsy report may be available.

8

Would you in the normal circumstances see a copy of the final autopsy report?

9

A. I would see many of them but it would be difficult to say the exact percentage.

10

Q. Again is that a matter you

11

would receive a copy upon initiation?

12

A. Yes.

13

Q. By you?

14

A. Yes.

15

Q. It doesn't happen automatically?

16

A. Correct.

17

Q. In situations where you have actually attended the autopsy, Dr. Freedom, have observed or participated in the autopsy with respect to the heart, would you in those situations in accordance with your normal practice seek and obtain a copy of the preliminary and ultimately a copy of the final autopsy report?

18

A. I would often request that

19

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such a copy be made available to the referring or
ward cardiologist but not necessarily to myself.

4

5

Q. All right. And if you are
not in respect of any particular patient the
referring physician, would you in that circumstance
ultimately seek and obtain a copy of the preliminary
and final autopsy report?

8

9

A. Probably not.

10

11

12

13

14

Q. Now as I understand it,
Dr. Freedom, in addition to your other responsibili-
ties, you are one of the staff cardiologists who
performs on frequent occasion cardiac catheteriza-
tions in respect of cardiacl patients. Is that
correct?

15

A. Correct.

16

17

Q. Who in addition to yourself,
Dr. Freedom, performs cardiac catheterizations in the
Hospital?

18

19

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A. Well, I think the numbers
of staff cardiologists have changed. I think if we
go to back to the summer of 1980 it would be myself,
Dr. Peter Olley, Dr. Ted Izukawa, Dr. Walter Duncan
and I think Dr. Rowe occasionally would do emergency
call.

Q. Now can you help us,



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2

Dr. Freedom, is there a staff cardiologist on the
weekends assigned to be responsible for the cardiac
catheterization lab so that if a cardiac catheteriza-
tion was necessary on the weekend a particular staff
cardiologist would be called in to perform that
procedure?

7

A. Well, as I mentioned, those
physicians that I just recited do cardiac catheter
studies. Dr. Fowler and Dr. Vera Rose do not. So
when they are on call for weekend one of us will
back them up just for catheterizations or other
type of emergency, pacemaker insertions and that
type of thing.

14

Q. And when you, sir, are
ordinarily on call on a weekend I take it part of
your responsibilities would be to perform such
cardiac catheterizations as might be required?

17

A. Correct.

18

Q. And that would apply as well
to the other staff cardiologists who do perform
cardiac catheterizations?

21

A. Correct.

22

THE COMMISSIONER: Dr. Freedom, is
that the right word, "catheterization"? We have
heard both. Don't worry about it too much. I can

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always look it up.

3

MS. CRONK: I bow to any pronunciation
you prefer to advance.

5

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THE COMMISSIONER: No, no. This is
the only way I find out from the experts.

7

8

THE WITNESS: I say catheterization.
I know some of my Canadian colleagues say catheters.
They do a catheter study.

9

10

11

THE COMMISSIONER: But you don't
use the word that Miss Cronk has been using, namely
catheterization?

12

THE WITNESS: No.

13

14

MS. CRONK: I think that is a two to
one. I will take that...

15

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19

Q. In the course of your
responsibilities, Doctor, then would I fairly take
it that with respect to patients in the cardiology
wards you would have familiarity with them first if
you were involved in some direct fashion in their
care and management during life on the ward?

20

A. Correct.

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Q. In other circumstances or in
addition to your direct involvement you would have
some familiarity with them if you had performed or
had participated in a catheter procedure on that
child?

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A. Correct.

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A. Yes. And in addition, the

morning work conferences and the sign-out rounds in
the evening.

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Q. Right. We have heard,

Doctor, of a series of meetings and conferences held
to review both the clinical status of children in
the Hospital and as well the circumstances surrounding
any death of a cardiology patient. You have mentioned
the staff cardiology conferences that are held in
the morning and I take it that when you are on duty
as a matter of course you attend those meetings?

20

A. Correct.

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Q. You have mentioned as well
pathology meetings that are held once a week in the
Pathology Department on Mondays I believe you said.

A. Correct.



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Q. Do you as a matter of course participate in those conferences?

A. Yes.

Q. If a cardiology pediatric patient had died during the preceding week, the week preceding the pathology meeting on Monday, Dr. Freedom, are the circumstances of that death and the clinical condition prior to death discussed at the pathology conference?

A. Usually there is a lag period between when a youngster dies and when the material is finalized through the Department of Pathology.

Q. Can you help us, Dr. Freedom, as to what the normal lag period is between time of death of any particular patient and discussion at a pathology conference concerning that death?

A. Often four to six weeks.

Q. Would it be fair to say that would be coincident in point of time with the preparation of a preliminary autopsy report in most cases?

A. No. I would say it is very important to have a histology done as well and the preliminary often focuses on gross findings, and by the time we would want to present it to the Monday



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cardiovascular conference we would want the complete
histopathology and any other special studies.

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Q. So at the time a particular death was discussed in a pathology conference the preliminary autopsy report might well have been available but the final autopsy report may or may not be available?

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A. Correct.

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Q. Right. Now we have heard in addition, Dr. Freedom, of surgical conferences held once a week. Do you participate in those conferences?

A. Yes.

Q. What is your role in those conferences?

A. There are at least two surgical conferences. One is conducted on Monday mornings with the ward chiefs, or back in 1980 the ward chief, the residents and fellows both on the pediatric side and the surgical side. So when I was ward chief I would participate in that Monday morning surgical conference. And the focus of that conference is to review in depth all patients scheduled for surgery that week.

The second conference that I would



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attend on a weekly basis whether or not I am ward chief is held Monday afternoons, and that is a conference where one reviews patients that either need surgery or where there is a consideration of surgical approaches, and I would attend those every week.

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Q. Now, Doctor, when you referred to patients who either required surgery or who are potential candidates for surgery, are these cardiac patients at large or inclusive of cardiac pediatric patients on the cardiology wards?

A.

Yes, some of those patients will be on the fourth floor, 4A/B; others will be in the Intensive Care Unit 7G and many of them were ambulatory patients at home.

Q.

Now, Doctor, during the period of time in which this Commission is interested, that is July of 1980 to March of 1981, were the pathology conferences that you described held on a weekly basis to the best of your knowledge?

A.

No, they were not.

Q.

How many weekly pathology conferences were held in that period so far as you recall?

A.

At least two; possibly three.



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Q. Well now, Doctor, perhaps I have confused this because we have heard evidence from Dr. Rowe as to both the holding of a pathology conference and as well a weekly pathology review conducted by Pathology Department.

A. Right.

Q. Are those two different types of meetings?

A. Yes, they are.

Q. And in the discussion we have just had concerning your involvement on a weekly basis at pathology conferences, were you referring to the first and not the weekly pathology reviews that are conducted?

A. I was referring to a cardiovascular conference that is co-chaired by myself and a member of the Department of Pathology where the focus is primarily on the cardiac cases.

Q. Right. Now in addition to those meetings, Dr. Freedom, are there as well weekly pathology reviews conducted by the Pathology Department?

A. Yes.

Q. And would you participate in the normal course in those meetings?



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A. No, I would not.

3

Q. Are they particular to members

4 of the Pathology Department?

5

A. Would you repeat that?

6

Q. Are they particular to members

7 of the Pathology Department?

8

A. Yes.

9

THE COMMISSIONER: I am afraid I am lost at this point. Can you help us out? What are the ones that take place on Monday afternoons?

11

THE WITNESS: Those are the conferences where the focus is primarily on the children with congenital heart disease that have died either in the institution. We get some specimens of our patients that have died elsewhere that are sent in to us.

16

THE COMMISSIONER: Don't describe them too much. Do they take place every Monday?

18

THE WITNESS: During the period that Miss Cronk just referred to, July '80 to March '81, we had only a few of them. In the past year they have been more regular.

22

MS. CRONK: As I understood it, Mr. Commissioner, if I can be of assistance, those meetings that Dr. Freedom has just described are

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those that I described as pathology conferences.

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Q. In addition to that, or separate and distinct from that there are weekly pathology meetings in which you do not participate; is that correct?

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A. Correct.

8

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Q. Now we have heard as well, Dr. Freedom, of another form of conference called a cardiac pathology conference.

10

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12

Again is that referable to either of the two kinds of pathology meetings you have just described?

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A. Yes. The Monday afternoon conference that I co-chair with the Department of Pathology staff is what I would refer to as the cardiac pathology conference.

16

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THE COMMISSIONER: Is that the same one that you were discussing about the one that is supposed to take place on Monday afternoon but there were only two or three in this period?

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THE WITNESS: Correct.



DM.jc

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2 Q. And then finally, Doctor, perhaps
3 to lend even further confusion to the situation, we
4 have heard evidence about another kind of conference
5 that is held in the Hospital and that has been
6 described as a Surgical Pathology Conference. Can
7 you help us, is that something different than the
meetings we have been discussing so far?

8 A. Well, I know there is a
9 separate review of the cardiac cases by the surgeons.
10 I am not certain if it is called the Surgical
11 Pathology Conference however, I have never heard it
12 referred that way.

13 THE COMMISSIONER: Are you part of it?
14 THE WITNESS: No, I am not.

15 MS. CRONK: Q. Dr. Freedom, we have
16 also heard evidence from Dr. Rowe regarding what he
17 described as a mini sabbatical which he suggested that
18 you took at some time I believe during the fall of
1980.

20 A. Right.

21 Q. Can you assist me as to when you
22 took that sabbatical?

23 A. Yes. It was beginning during the
24 summer of 1980 through December, I think it was
basically to the new year, where I had requested time
to finish a textbook I was doing.

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Q. And did that sabbatical result in any reduced duties, or responsibilities, on the cardiology wards for you at that time?

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A. Yes. I think Dr. Rowe tried to protect me a little bit that six months, so I had relatively little ward duty. I still saw the same number of outpatients, I had the same night duty but I certainly had less ward duty.

9

10

Q. And by ward duty do you mean during the day, or are you including weekends on call?

11

12

A. No, I had that, but I had less duty as ward chief.

13

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Q. Now as I understand it on that issue, Dr. Freedom, you were a ward chief in two periods during the nine-month time frame that we are looking at. Please correct me if I am wrong, but my understanding is you were ward chief from August 11th, 1980 until August 22nd, 1980, is that correct?

A. Right.

Q. And as well you were ward chief during the month of October, 1980?

A. Correct.

Q. During the nine-month period upon which we have just focussed, were you ward chief on any other occasion?



B.3

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A. I would have to look at the
schedule, but I don't believe so.

2

Q. Now Doctor, are you aware of the
identity of the 36 children in respect of whose
death this Commission is concerned?

3

A. Yes, I am.

4

Q. Can you help me, before we turn
to specific cases, Dr. Freedom, at the outset, with
what in your judgment would be an appropriate range,
or level, therapeutic level for digoxin in a cardiology
paediatric infant receiving digoxin therapy in the
Hospital?

5

A. I think there is always the
dilemma as one treating a number, as one treating
a patient. I think there are certain guidelines that
we have been given where a therapeutic level is 1 to

6

2.5.

7

MR. MARSHALL: Mr. Chairman, I am

8

sorry to interrupt.

9

THE COMMISSIONER: Yes.

10

MR. MARSHALL: I wonder if that question

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can be qualified in terms of time? Whether it is
being asked as of the so-called epidemic period, or
as of now, that may be of some significance in terms
of this Commission.

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2 MS. CRONK: Quite right, Mr. Commissioner,
3 I will be glad to reframe my question.

4 Q. Dr. Freedom, if I could ask you
5 again to concentrate on the time period of July 1980
6 through to March of 1981. During that period of
7 time what did you then consider, as best you can now
8 recall, to be an appropriate therapeutic range of
digoxin level for cardiac/paediatric patients?

9 A. 1 to 3.

10 Q. And is that the range that you
11 felt to be then acceptable for infants on digoxin
therapy?

12 A. I think they were soft guidelines.
13 I think some patients would require more digoxin than
14 others.

15 Q. And when you say 1 to 3, I take
16 it, Doctor, you are referring to 1 nanogram to 3
17 nanograms per millilitre?

18 A. Correct.

19 Q. The first child that I understand
20 you had some direct involvement with in terms of the
care and management of the patient's condition was
21 Laura Woodcock, Dr. Freedom. The medical record for
22 that child, Mr. Commissioner, is Exhibit 117.

23 THE COMMISSIONER: Yes. I wonder if we

24

25



B.5

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2 could, you threatened us just a minute ago with
3 listing the patients for whom Dr. Freedom did have
4 special care, and it might be easier for us if you
5 could list them now.

6

MS. CRONK: By all means, Mr.
7 Commissioner, subject of course to Dr. Freedom's
confirmation in evidence.

8

THE COMMISSIONER: Yes, we will put it
9 in the form of a question, are these the children?
10 Yes, all right.

11

MS. CRONK: Q. As I understand it,
12 Dr. Freedom, and we can go to the charts if you will
13 require it, there are a number of children with whom
14 you had direct involvement in terms of the care and
15 management of the patient during life. Again, based
16 on my review of the medical records, they are Laura
Woodcock, is that right?

(2)

17

A. No.

18

Q. All right, we will come back to
Laura Woodcock. David Taylor?

19

A. Yes.

20

Q. Lillian Hoos?

21

A. I believe I did the catheter
22 study on Lillian Hoos, but other than that I, as on
23 night call, had relatively little direct contact.

24

25



B. 6

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2 Q. All right. Dion Shrum?

3 A. Yes.

4 Q. Kelly Monteith?

5 A. Yes.

6 Q. Paul Murphy in a limited sense?

7 A. No, I was ward chief when Paul
Murphy was on the service and I participated in his
8 care several times over a number of years.

9 Q. Antonio Velasquez?

10 A. Yes.

11 A. Brian Gage?

12 A. Yes.

13 Q. John Onofre?

14 A. Yes.

15 Q. Real Gosselin?

16 A. No.

17 Q. I do not believe you had direct
involvement in the care of Stephanie Lombardo?

18 A. I believe I did the catheterization
on Stephanie Lombardo.

19 Q. Jesse Belanger?

20 A. Yes.

21 Q. Janice Estrella?

22 THE COMMISSIONER: Just a moment, please,
23 Lombardo you say the catheter?

24

25



B. 7

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2 THE WITNESS: Yes, I would have to
3 check the records but I believe that is correct,
4 Mr. Commissioner.

5 THE COMMISSIONER: That's fine.

6 MS. CRONK: Q. Jesse Belanger?

7 A. Yes.

8 Q. Janice Estrella, were you involved
in the direct care and management of that child?

9 A. No.

10 Q. It is my understanding that you
11 were not, Dr. Freedom. Baby Leith?

12 A. No.

13 Q. Kevin Pacsai?

14 A. No.

15 Q. Baby Gardner?

16 A. Yes.

17 Q. Allana Miller?

18 A. Yes.

19 Q. And on Justin Cook I believe you
performed a cardiac catheterization?

20 A. Correct.

21 Q. Several of those children, Mr.
Commissioner, I will be returning to by virtue of
22 involvement at one particular point in time of Dr.
23 Freedom.

24

25



B.8

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2 THE COMMISSIONER: Yes, all right.

3

4 MS. CRONK: Q. Subject to that

5

6 qualification, Dr. Freedom, did you have any direct
7 involvement in the care and management of the balance
8 of the 36 children that this Commission is concerned
9 with?

10

A. No.

11

Q. If we can turn then first, Dr. Freedom, to the case of Laura Woodcock. I think the Registrar has given you the medical record for that child.

12

As I understand it, Dr. Freedom, Laura Woodcock was admitted to the Hospital for Sick Children on June 26th, 1980, at 18 days of age, having been transferred from Oshawa General Hospital for investigation of both congestive heart failure and forgive me if I mispronounce it, hyperbilirubinemia, is that correct?

13

A. Correct.

14

Q. And she died subsequently at the Hospital for Sick Children, as we know, on June 30, 1980, at approximately 9:40 a.m. As I understand it, Dr. Freedom, you were the referring physician at your hospital for this patient, is that correct?

15

A. Correct.

16

17



B.9

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2 Q. We have heard in prior evidence,
3 and I ask whether or not this accords with your
4 understanding of the arrangements Dr. Freedom, that
5 although a particular staff cardiologist might be
6 described in the medical record of any given child,
7 might be described in the medical records of any
8 given child as the referring physician in the
9 Hospital, that does not necessarily mean that that
10 physician was involved directly with ongoing care of
the patient, is that correct?

11

A. Correct.

12

Q. However, as I understand it, in
this particular case, Dr. Freedom, you were as well
staff cardiologist on duty the night of her death,
that is June 30th, 1980, is that correct, sir?

13

A. No, that is not correct.

14

Q. Can you help me as to who the
ward chief was on the night of her death?

15

A. I believe it was Dr. Richard Rowe.

16

Q. You did, however, Dr. Freedom,
as referring physician for this child, write to Laura
Woodcock's family doctor, Dr. MacGillivray, on July
7th, 1980 reporting on her death. I refer you to the
reporting letter found at page 1 and page 2 of the
record.

17

A. Correct.

18



B.10

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Q. Is that your letter, sir?

3

A. Yes.

4

Q. Can you help me on the matter of
5 reporting letters, Dr. Freedom? In situations where
6 you were designated as the Hospital for Sick Children
7 referring physician for a particular patient, was it
8 part of your responsibility in respect of that patient
9 to report to the outside referring physician as to
her progress, or his progress from time to time?

10

11

12

13

14

A. I would say it was primarily
my responsibility to summarize the time of death, or
discharge the course of events. I would leave it to
the ward chief and his staff, or her staff, to
communicate to the referring physician during the
immediacy of the hospital stay.

15

16

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Q. Do I take it correctly then that
when a child was either discharged from the Hospital,
or had died in the Hospital, such that a death report
was required, the preparation of either those two
kinds of reports would be your responsibility where
you were the referring physician?

A. Correct.

Q. Now as a general matter, prior to
preparing such reporting letters, Dr. Freedom, would
you have access in the normal course to medical
records of the child?



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2 A. Not invariably.

3

Q. In a situation, for example,

4

where a child died on either Wards 4A or 4B during the
evening and the reporting letter was prepared after
the death, would you, in the course of preparing that
letter, have access in those circumstances to the
medical records of the child?

5

A. I would often try and obtain

6

the chart. Unfortunately from the time the chart left
the Department of Pathology if there was an autopsy,
until it wound its way back to Medical Records to be
bound, there was often considerable difficulty in
obtaining the chart. So when I was able to have a
chart available I would have it so, otherwise I would
make do from my knowledge of the patient, the morning
rounds and talking with the Fellow on call, or
resident on call.

7

Q. Now in the situation where the

8

medical record itself, for the reasons you have
outlined, was not available to you, and there had been
the death of a patient during the evening on the
wards, would you, prior to writing a reporting letter,
in the normal case have attended at the autopsy of the
child and observed the gross anatomy of the heart?

23

A. I think those are two questions,

24

25



B.12

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2 Miss Cronk. I would often have access to the heart
3 and its findings. It would be unusual that I would
4 be there for the entire autopsy.

5 Q. Fair enough, Doctor, I understand.

6 Now in addition you mentioned that you would have
7 some familiarity with the child's case by virtue of
morning rounds on the wards?

8

A. Correct.

9

10 Q. And in addition you would have
access I take it to the resident and/or the staff
11 cardiologist who might have been present on the ward
12 at the time of the child's death?

13

A. Correct.

14

Q. And I assume, and correct me if
I am wrong, Dr. Freedom, that if you had any
particular questions regarding that child's condition,
and in the circumstances of death regarding the manner
or the modeof death, those would be matters that you
would feel free to raise, either with the resident
or the staff cardiologist prior to preparing your
reporting letter?

15

A. Correct.

16

Q. Do you as a normal matter, Dr.
Freedom, and again in the time period we are talking
about, July 1980 to March 1981, did you prepare these

17

18

19



B.13

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2 reporting letters yourself, or were they prepared on
3 your behalf?

4 A. I would have to see each letter
5 to which you are referring, the majority of letters
6 I would dictate myself on individual patients.

7

Q. Specifically in the case of
8 Laura Woodcock and the record before you, did you
9 prepare this reporting letter to Dr. MacGillivray
yourself?

10

A. Yes, I did.

11

Q. And if we could specifically look
12 at the reporting letter, Dr. Freedom, in the second
13 paragraph of your letter you report upon what I take
14 to be the clinical impressions that you had formed
when the child was alive?

15

A. Yes.

16

Q. And concerning her condition,
17 and you indicate first that she was felt to have:

18

" ... mild pulmonary stenosis and
19 this was confirmed by non-invasive
20 assessment including her echocardiogram."

21

A. Correct.

22

Q. Do I take that correctly to mean
23 that no cardiac catheterization was performed on this
24 child?

25



B.14

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A. Correct.

3

4

Q. You then indicate further again
in the second paragraph, Dr. Freedom:

5

6

7

8

"Far more disturbing was her severe
and persistent jaundice, and indeed
arrangements were being made for her
to be evaluated, perhaps transferred,
to the liver or G.I. service."

9

A. Correct.

10

11

12

13

Q. As I understand it, Dr. Freedom,
jaundice was the condition noted on the very first
day of her admission at the Hospital for Sick
Children on the 26th of June?

14

A. Correct.

15

16

Q. And was that as well a condition
that had been noted in fact during the post natal
period of this child while she was at home?

17

A. Yes.

18

19

20

Q. And I take it that from the
contents of your letter to Dr. MacGillivray that the
jaundice persisted following admission and was seen
to be her predominant problem?

21

A. Correct.

22

23

Q. Throughout the period of her
hospitalization, short though it was, Doctor, would

24

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B.15

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2 it be fair to say that the problem of her persistent
3 jaundice was considered of greater significance than
4 the cardiac difficulties which she appeared to be
5 presenting?

6 A. I think it was my impression at
7 the time that they were concerned this youngster had
8 relatively mild structural heart disease. They felt
9 there might be a link between the liver disease and
10 heart muscle disease in terms of her viral process.
11 Certainly the jaundice was of grave concern to the
floor.

12 Q. Was there any observation or
13 conclusion during her hospitalization that she was
in congestive heart failure, Doctor?

14 A. There was a conclusion that she
15 was not in congestive heart failure.

16 Q. Doctor, can I ask you to turn
17 very briefly to page 43 of the record, which we will
18 see is an excerpt from the progress notes for the
19 27th of June, 1980. We see recorded there under the
20 word "Impression" the condition of the child as
21 direct hyperbilirubinemia, and again I suspect I
mispronounced that?

22 A. Not bad.

23 Q. As I understand it, Doctor, well,

24

25



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Freedom, dr.ex.
(Cronk)

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B.16

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2 perhaps you can explain very briefly for us what that
3 condition entails?

4 A. Well, hyper means excessive
5 amount of bilirubin, and when they say impression
6 direct hyperbilirubinemia this refers to increased
7 bilirubin in the blood system.

8 Q. That was the condition as I
9 understand it, Dr. Freedom, that in fact had been
10 diagnosed at the referring hospital as well?

11 A. Correct.

12

13

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Q. And, Dr. Freedom, in a

situation, would you agree with me that that is not
an unusual finding?

A. No, I would not agree with that.

I would think that persistent and deep jaundice is
an unusual finding.

Q. I see.

THE COMMISSIONER: It is an unusual
finding for what?

THE WITNESS: Well, for a normal baby,
and I guess this is what you were getting at.

THE COMMISSIONER: That is what sick
babies are though, I mean, there is an unusual -- I
thought your question was, would a child with jaundice,
would this be unusual. Was that your question?

MS. CRONK: Q. Well, I can put it in the
reverse, Dr. Freedom, as well. In situations where
a patient is deeply jaundiced, in the situation of
this child particularly, that is not, I would have
thought, an unusual occurrence to see direct
hyperbilirubinemia.

A. It is difficult to be deeply
jaundiced without having hyperbilirubinemia.

Q. Thank you.

THE COMMISSIONER: In fact, it is



1

2

expected.

3

THE WITNESS: Correct.

4

THE COMMISSIONER: Yes, all right.

5

MS. CRONK: Q. And we see on the
same excerpt from the progress notes, Dr. Freedom,
at the bottom of the page, that Doctor, and I believe
it is Dr. Dunn, expressed surprise or some puzzlement
at least, given what was felt to be the child's
cardiac condition at that time, as to the changes
that were being then exhibited on the chest x-ray
of the child.

12

A. Correct.

13

Q. And based on your knowledge of
the clinical condition of this child, would you agree
with me that that puzzlement in part, if not entirely,
resulted from the fact that the child was not felt
to be in congestive heart failure?

17

A. Again, Ms. Cronk, I didn't
see the youngster at the time nor see this x-ray. I
have seen the comment about the x-ray, so, I would
think you would probably have to refer to Dr. Dunn
for it.

22

Q. All right. And on the same
day, Dr. Freedom, as I understand it, Laura Woodcock
was in fact found, as was suspected to have an

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elevated bilirubin level in her blood?

3

A. Correct.

4

5

6

We turn to page 45 of the progress notes. We see that a bilirubin level of 20.4 and a direct at 10.4 is noted at the bottom of the page.

7

8

A. Yes.

9

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All right. And then to briefly summarize, Dr. Freedom, the terminal events experienced by this child, on June 30th, and I am referring now to pages 48 and 49 of the progress notes, at approximately 3:00 a.m. her condition changes, the child vomits, the apex becomes irregular, at 4:00 a.m. there is a note that she appears however to be stable; at 6:00 a.m. there is apparently another episode, the blood pressure drops, the apex becomes irregular, the child vomits again; 7:00 a.m. Dr. Schaffer sees her, the blood pressure is further decreased, apex is still irregular, vomits again; then at 7:30 a.m. there is a major disturbance, it is recorded as complete heart block with AV disassociation. I'm not reading on page 50, Dr. Freedom, /the progress reports.

22

A. Yes.

23

Q. Atropine is then prescribed and

given.

24

25



1

2 A. Yes.

3

4 Q. Blood pressure goes back up,
5 the child is recorded as being more stable but
6 Dr. Schaffer at that point, in his note at page 50,
7 he is questioning, at the bottom of the page, toxicity.

8

9 Did you have any discussions with
10 Dr. Schaffer following the death of this child,
11 Dr. Freedom, as to what he was referring to in his
12 query about toxicity?

13

14 A. I don't remember if I had a
15 specific conversation with Dr. Schaffer about that.

16

17 Q. Do you have any understanding
18 as to what concerns Dr. Schaffer was addressing in
19 making a note in the progress notes as to toxicity in
20 this child?

21

22 A. Well, I would have the same
23 understanding of this as you do, Ms. Cronk. It says
24 "toxicity, electrolyte imbalance", and I would think
25 that he would be concerned of high potassium levels
in a sick baby and, secondly, bilirubin toxicity.

26

27 Q. All right. That note,
28 Dr. Freedom, is made at 7:30 in the morning.

29

A. Correct.

30

31 Q. The next entry on the next
32 page of the progress notes at 9:35 a.m., the child

33

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has a cardiac arrest and is seen by Dr. Rowe, and
we have heard from Dr. Rowe that the note on page 51
is his in the progress notes and he indicates that
the cause of the arrest of that episode was quite
uncertain and that there is no indication of
impending decay in the condition; plans in fact were
in progress to transfer the child to the GI service
that every week. The arrest note then concludes
there was no indication -- I'm sorry, I have read
that --

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"The cause of the episode is thus quite
uncertain. There is no reason for
the sudden unexplained arrest based on
the clinical evidence. The coroner
was notified by Dr. Contreras."

Part of that language, Dr. Freedom,
appears in your reporting letter to Dr. MacGillivray
on page 1 of the record.

A. Yes.

Q. I take it you agreed with the
clinical comment expressed in the arrest note, that
the arrest was sudden and unexpected?

A. Correct.

Q. What did you mean, Doctor,
when you reported to Dr. MacGillivray specifically that



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the death was sudden and unexpected?

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A. Well, sudden I think speaks for itself. I meant it happened suddenly and unexpectedly means that it was unanticipated in the time that it happened.

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Q. Well, when you made the comment that the death was sudden and unexpected,

Dr. Freedom, did you have access prior to preparing the reporting letter to the progress notes and specifically the note that had been made by Dr. Rowe and the final arrest note itself?

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A. No. I believe I spoke with Dr. Rowe and he reviewed the events leading to this youngster's death but I don't recall specifically if I had the chart at that time.

Q. Was this then a conclusion

or observation made by Dr. Rowe with which you concurred?

A. Correct.

Q. All right. And when you

referred to the death as having taken place suddenly and unexpectedly, was that statement made in the context of what had been described to you as the condition of the child before the arrest and as well the terminal events that then ensued?



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A. Yes.

3

Q. And by use of the word

4

"unexpectedly", Dr. Freedom, and as you are undoubtedly aware we have had considerable evidence as to the way in which doctors use that phrase as opposed to perhaps the way laymen or lawyers would use that phrase, did you have in mind the timing at which this child died?

5

A. Yes. I think that I was certainly concerned, as was the ward staff, that this child had a disease and that was yet undefined; whether it was a viral process or an intrinsic abnormality of the liver. The ward staff did not anticipate that this baby would die at that time and I would, or did use the word "unexpected" in that context, lack of anticipation.

6

Q. Were you present at the cardiology, the morning cardiology conference the morning after her death, Dr. Freedom, as best as you can recall?

7

A. I can't recall.

8

Q. Do you recall whether at that meeting or in general discussions amongst the staff cardiologists, a consensus or opinion as to the probable cause of death of this child being expressed?

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A. I can't remember the exact time frame work, whether it was that day or the next few days, but I do recall a concern that perhaps this youngster had a viral process affecting heart and liver.

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Q. Based on your own discussions, Dr. Freedom, prior to preparing this reporting letter and your own knowledge from the morning rounds of this child's condition, did you yourself formulate a view as to the probable cause of death of the child?

12

13

A. I thought it was most likely due to overwhelming viremia.

14

15

Q. And by that do you mean viral causes?

16

A. Correct.

17

Q. All right. Did you attend

18

at the post mortem of this child, Dr. Freedom?

19

20

A. I can't remember, Ms. Cronk, whether I was there when they did it or whether I had access after it had been completed.

21

22

23

Q. I asked that question, Dr. Freedom, because in the balance of your letter to Dr. MacGillivray of course you refer to the findings at postmortem examination.

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A. Correct.

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Q. Do you have any specific

recollection of having yourself observed the heart
of this child at post mortem?

6

7

A. Yes, I do remember looking at
the heart.

8

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Q. Was there anything evident

in the postmortem findings or on your examination of
the heart which either confirmed or negated your
earlier view that the probable cause of death was
related to viral causes?

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A. Well, again, the liver, as I

said in my note, and I will just have to use that

to refresh my memory, they did a postmortem

cholangiogram which is a technique by which one tries

to define whether or not there are gross abnormalities

of the drainage system from the liver and it said

in my letter that there was not. So, it would

suggest to me, and again, I'm not a liver pathologist,

that the liver was abnormal and, again, why is the

liver abnormal, perhaps a viral infection.

21

22

23

Q. Blood cultures were as well

ordered in respect of this child because of this

suspicion of infection, is that correct, Doctor?

24

25

A. Yes.



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Q. And either at the time of preparing your reporting letter or subsequently, did you become informed as to the results of those cultures?

6

A. I can't recall specifically.

7

Q. All right. It is my understanding, Dr. Freedom, and please feel free to correct me if this is not in accord with your understanding, that the suspicion of infection was in fact negated by the culture results that were obtained after the child's death. That was ruled out as a likely contributing factor.

13

A. No, I think you are mistaken.

14

I think that a bacterial infection was ruled out and I would agree with that, but it is sometimes very difficult to rule out viremia because blood cultures themselves would not necessarily detect that.

17

Q. Well, Dr. Freedom, can you assist me. Did you ultimately receive a copy of the final autopsy report for Laura Woodcock?

20

A. I can't remember specifically;

21

I may have.

22

Q. Do you recall receiving a copy of the preliminary autopsy report?

23

A. Not specifically.

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Q. To assist you in that regard fairly, Dr. Freedom, if you turn to page 29 of the record, which is the preliminary autopsy report. Do you have that, Doctor?

A. Yes.

Q. On page 2 the indication is made that copies were sent to a number of individuals, including yourself, and similarly, to be fair to you, on page 33 of the record, which is the fourth page of the final autopsy report, again, an indication is made that a copy was sent to you. Sitting here today, do you have any recollection of having received and reviewed either of those two autopsy reports?

A. No.

Q. All right.

A. That doesn't mean it wasn't sent. I may have reviewed it but I just can't recall it.

Q. No, I understand that, Doctor, thank you.

With respect to the suspicion or indication that you felt was evident that this child's death might be attributable to that form of viral infection, did you participate, Doctor, in the



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decision to notify the coroner of this child's death?

3

A. No.

4

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Q. After the dictation and the preparation of your reporting letter and after the final postmortem results were obtained in respect of the child, did you alter your views in any way as to the likely cause of death of the child?

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A. Yes, in the sense that the heart muscle did not show evidence of severe inflammatory response. So, I felt that it would be unlikely that a myocardial heart muscle infection would be responsible for this death in isolation.

Q. You felt it unlikely?

A. Unlikely.

Q. Can we go this far as well,

Doctor, that on the basis of the postmortem findings, as set out first in the preliminary autopsy report, and then the final autopsy report, that it is equally unlikely, or at least it was the opinion of the staff cardiologist that it was equally unlikely that the congenital heart condition of the child itself accounted for the death of the child?

A. Correct.

Q. Sitting here today,

Dr. Freedom, do you have an opinion as to the



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3 probable cause of death of this child in light of
those postmortem findings?

4

5

6

7

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A. You know, at post mortem the youngster had fluid in chest cavities, in the abdomen, and I would wonder whether this process was a toxic process of the bilirubin directed towards the central nervous system.

9

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13

Q. And do you find support for that concern, Doctor, in anything contained in either of the preliminary or final autopsy report?

A. Yes, first of all they talk on number one and two, the patient had extensive bilateral pneumonia.

14

15

THE COMMISSIONER: I'm sorry,

Doctor, what are we looking at?

16

THE WITNESS: That's on page 29.

17

THE COMMISSIONER: All right.

18

MS. CRONK: Q. You are referring now, Doctor, to the preliminary autopsy report.

19

20

A. Let me go back to the final autopsy report.

21

22

Q. That starts at page 30,

Dr. Freedom.

23

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A. Again, if it described giant cell formation, Ms. Cronk, that is not just based on

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preliminary information, that is using a microscope.
So, this youngster had extensive pneumonia bilateral
with congestion and edema; that's number one.
Number two, he had a severe cholemsis, and that
meansplugging of the liver with bilirubin. There
was congestion of the organs, as listed in number
seven. So, again, this was obviously an ill youngster
but it was apparent that the heart disease holds
relatively little risk to this baby in isolation.

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Q. Could you turn as well,
Doctor, to page 33, the final page of the final
autopsy report.

13

A. Yes.

14

Q. And address your attention to
the final paragraph of the final autopsy report.

15

A. Yes.

16

Q. The second last sentence.

17

First of all, the observations or conclusions reached
following the final autopsy are set out in that
penultimate paragraph and then the observation is
made:

21

"The exact cause of the sudden cardio-
respiratory arrest is uncertain, no
organisms were cultured from the
lungs at post mortem, but the child

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"was on intravenous antibiotics."

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A. Correct.

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Q. In light of the significant matters which you have in your view pointed out in the final autopsy report, do I take it that you are satisfied as to the probable cause of death of this child in the arrest that she sustained, notwithstanding the observations made in the final paragraph of the autopsy report?

A. Yes. I believe it is not uncommon, Miss Cronk, to have a child or an infant with a viral process causing pneumonia where the virus is not invariably cultured. I would be satisfied that it was unlikely that this was caused through a bacterial process.

Q. And the lack of any bacterial reading on the cultures taken post mortem is in fact alluded to in the autopsy report?

A. Correct.

Q. Thank you. Did you subsequently become aware, Dr. Freedom, after the autopsy reports were available, as to the results of digoxin assay tests which had been conducted by the Centre of Forensic Sciences in respect of tissues from the body of Laura Woodcock?



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(Cronk)

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A. I can't remember specifically.

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We have had so much information about digoxin pre
and post mortem over the past two years, two and a
half years.

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Q. And I take it you are not
familiar with the details then of any of those
findings?

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A. No.

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2 Q. Would I be correct then in
3 assuming that the findings of those assays were not
4 relied upon by you in expressing the opinion as to
5 the probable cause of death you just outlined?

6 A. Correct.

7 Q. Can we turn then, Doctor, to the
8 next child who died in the Hospital with whom as I
9 understand it you had some direct involvement? That
is David Taylor whose record is Exhibit 43.

10 A. Correct.

11 Q. Stopping there for just a moment
12 may I confirm, Dr. Freedom, in light of our earlier
13 discussion that you had no direct involvement in the
14 care and management either of the Perreault baby or
in respect of Andrew Bilodeau?

15 A. Correct.

16 Q. Would it be fair as well for me to
17 suggest that you were, however, although you had no
18 direct involvement, aware of their deaths by virtue
19 of your ongoing responsibilities on the cardiology
wards? You were aware that they were patients and
20 had died?

21 A. That is correct.

22 Q. And their deaths I take it would
23 have been discussed at the morning staff cardiology

24

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D.2

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2 conferences held on the mornings following their
3 deaths?

4 A. Correct.

5 Q. Dealing specifically then,

6 Doctor, with David Taylor, we have heard in prior
7 evidence that David Taylor was born on April the 20th,
8 1980, was admitted to the Hospital for Sick Children
9 on July 25, 1980, and died two days later on July 27th.

10 As I understand it once again you are
11 designated as the referring physician for this child.

12 Is that correct?

13 A. Correct.

14 Q. Were you directly involved in the
15 care and management of this child, Dr. Freedom?

16 A. No, I was not.

17 Q. It is my understanding that
18 following a cardiac consultation in which you
19 participated the child was admitted specifically at
20 your request. Is that correct, Doctor?

21 A. Correct.

22 Q. And that consultation took place
23 on July 25th, 1980?

24 A. Correct.

25 Q. If I could refer you, Doctor, to
page 1 of the record, there is a one-page letter



D.3

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2 addressed to Dr. Conner. You have been kind enough
3 to provide me through your counsel with page 2 of
4 that letter. As I understand it that is a reporting
5 letter prepared by you and sent to Dr. Conner,
6 reporting upon the results of your consultation and
7 inspection and examination of David Taylor on the
25th of July?

8

A. Correct.

9

10 MS. CRONK: Mr. Commissioner, copies
11 of page 2 of that reporting letter were inadvertently
12 omitted from the record, copy of the record that was
introduced in evidence.

13

THE COMMISSIONER: Yes.

14

MS. CRONK: Counsel have been provided
with a copy.

15

16 THE COMMISSIONER: All right. We will
make it Exhibit 43A.

17

--- EXHIBIT NO. 43A: Page 2 of letter dated
July 28th, 1980, to
Dr. W.T. Conner.

18

19 MS. CRONK: Q. As I understand it,
20 Dr. Freedom, this child had been noted, as you indicate
21 in the first paragraph of your reporting letter to
22 Dr. Conner, to have a heart murmur at birth?

23

A. Correct.

24

Q. He was admitted to the Hospital

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D. 4

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2 as a result of the observation of that heart murmur
3 and because of what you describe as clinical
4 deterioration in his condition?

5 A. Correct.

6 Q. As I understand it again reviewing
7 your reporting letter you arranged both for an electro-
8 cardiogram and an echocardiogram to be conducted on
9 the day of admission; that is July 25th?

10 A. Right.

11 Q. And your conclusion following
12 those reviews, following your examination of the child,
13 was that he was suffering from severe aortic stenosis?

14 A. Right.

15 Q. And that he should be admitted
16 for anticongestive therapy?

17 A. Right.

18 Q. You also recommended, again
19 referring to your reporting letter, that a catheter
20 study and probably surgery take place within the
21 following week; is that correct, Doctor?

22 A. Correct.

23 Q. After the initial consultation
24 and examination that you had with this child did you
25 subsequently have any involvement directly in his care?

26 A. Later that afternoon I met with

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D.5

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2 Dr. Rowe, Richard Rowe, Dr. Vera Rose, and Dr. George
3 Trusler, Head of Cardiovascular Surgery, and we
4 discussed that I had admitted this baby from my office
5 in the Hospital, and we discussed whether we should
6 proceed with the catheter study that weekend or to
7 try and give the baby medications and hold the baby
until Monday.

8

9 The decision was reached during this
10 discussion to try and manage the baby medically until
Monday.

11

12 Q. I take it then no cardiac
catheterization was in fact performed over that weekend?

13

A. Correct.

14

15 Q. Would it be fair, Doctor, for us
16 to assume that had the surgery which you propose and
which you propose in your letter to Dr. Conner, had
they then been considered to be urgent, it is likely
17 a catheterization would have been proceeded with that
weekend?

18

19 A. There is always a dilemma when
20 dealing with babies with severe aortic stenosis.

21

22 As I mentioned in my letter the
mortality of this disease is high with or without
23 surgery. I think that there are - sometimes we feel
24 a baby would be better with medications despite

25



D.6

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2 realizing the baby is fairly precarious. So I think
3 it was a judgment call, and that is why I specifically
4 wanted to discuss it with those physicians I mentioned
5 a few minutes ago.

6

Q. Was it the consensus following
7 that discussion that you had or participated in with
8 Drs. Rowe, Rose and Trusler, that the catheter study
9 could wait to the following Monday to see how the
child progressed over the weekend?

10

A. Correct.

11

Q. Would it be fair to assume,
12 Doctor, that on the basis of that consensus there was
13 no apprehension on the day of the child's admission
14 on the Friday that the child would not in fact make it
till Monday to reach both the timing for the catheter
15 study and surgery?

16

A. I am not sure that is a fair
17 statement. I think that when we deal with babies
18 with aortic stenosis it has a high mortality. I think
19 like many things in life one wishes one had a crystal
ball. I think it was our hope and our anticipation
20 that this baby would survive the weekend, would be
improved, but whether there was an undercurrent of
21 concern I can't say. I know my own feeling of a baby
22 with aortic stenosis is I know they die suddenly, so
23

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2 there may well have been sort of an unstated concern
3 about this baby even holding off for the weekend.

(2)

4 Q. Well, fairly, Doctor, if we turn
5 to page 2 of your reporting letter to Dr. Conner, you
6 in fact make a similar observation, do you not, that
7 your overall experience with infants with severe
8 aortic stenosis in that age group suggest there was
9 a fairly substantial mortality.

10 You go on to say that there was really
11 nothing to gain from waiting.

12 I take that to mean nothing to gain
13 from waiting for performing surgery?

14 A. Investigations and surgery. Right.

15 Q. Now with all of that in mind,
16 with your concerns borne of your prior experience with
17 children with severe aortic stenosis, Doctor, would
18 you agree with me that as we have seen in the case
19 of several other infants, if the situation is considered
20 to be urgent it is not unusual for cardiac
21 catheterizations to be performed if not on the day of
22 admission of the child then over a weekend, notwithstanding
23 that the normal physicians on duty for those
24 purposes may have to be called in?

25 A. Correct.

Q. This child, Doctor, as I understand



D.8

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2 it, was prescribed digitalizing doses of digoxin and
3 they were administered following his admission on
4 July 25th. Is that correct?

5

A. Yes.

6

Q. And we have heard from Dr. Rowe
7 in evidence, Dr. Freedom, that following his admission
8 and following the administration of digitalizing
9 doses there seemed to be an improvement in the child's
10 condition; at least on July 26th until early on the
11 morning of July 27th.

12

To assist you, Doctor, can I refer you
13 to the progress notes on page 20 of the record? This
14 is an entry for July 27th, Doctor.

15

A. Yes.

16

Q. Now prior to the events set out
17 on July 27th, that is the terminal, the cardiac arrest
18 and the terminal events themselves, would you agree
19 with me that there is on the basis of the progress
20 notes no significant reason to be concerned about the
21 child's condition at that stage on the Friday and
22 the Saturday in the Hospital?

23

A. No, I wouldn't agree with that.

24

Q. Right. Can we look at page 19
25 of the progress notes, Doctor? On July 25th I take
26 that to be the Friday of his admission?

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D.9

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2 A. Yes.

3 Q. The child was digitalized, was
4 prescribed and administered lasix; an I.V. was started.

5 A. Yes.

6 Q. His blood pressure was considered
7 to be stable and even in all limbs. He was pale,
8 slightly cyanotic when upset.

9 There is an entry about the parents
10 and then the condition of the patient itself is
11 described as stable at the end of the shift; good
12 post lasic - I am having difficulty reading that?

13 A. Diuresis.

14 Q. Would you agree with me at that
15 stage, Doctor, on the Friday evening, the child's
16 condition appears relatively stable?

17 A. No, I do not.

18 Q. Can you help me then on what
19 basis or what matter of significance you see in the
20 progress notes to indicate there was some difficulty
21 at that stage?

22 A. Yes. This baby had severe aortic
23 stenosis, and that in itself doesn't make a baby blue
24 or cyanotic.

25 Q. When a baby is slightly cyanotic with
severe aortic stenosis, that would often suggest that



D.10

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2 the cardiac output is so low that the baby is
3 extracting all the oxygen he can, you know, in the
4 limbs, so when you see a baby with this type of
5 lesion and is cyanosed, it is often finding a very
6 severe impairment of cardiac function.

7 Q. I take it then, Doctor, that you
8 would read the entry slightly cyanotic when upset as
9 being an indication of impending alarm or at least a
10 deterioration of some significance in the child's
condition at that stage?

11 A. Again, Miss Cronk, I didn't see
12 the baby, but seeing this as written I would be very
13 concerned about any baby with a diagnosis of aortic
14 stenosis as being described as slightly cyanotic, as
for me it would raise major concern.

15 Q. At that stage, and in fairness
16 I appreciate you did not see the child personally, is
17 that indication of a slight cyanotic condition anything
18 more than a significant warning signal?

19 A. I guess it is like seeing a crack
20 in a dyke. You know, that is a warning of impending
21 disaster. So again if I am told that a baby with
22 aortic stenosis is cyanosed, my old boss at Harvard,
23 Dr. Nadas, would say that would be a very concerning
sign in this type of baby.

24

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D.11

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2 Q. So it is a significant warning
3 signal at that stage that there might be something
4 more serious happening in the child?

5 A. Correct.

6 Q. If we move to the 26th, the
7 Saturday.

8 A. Yes.

9 Q. And again the cardiac condition
10 is described: vital signs remain stable throughout
the night.

11 A. Yes.

12 Q. Slept well; colour remains pale.

13 A. Yes.

14 Q. Playful, alert with feedings.

15 A. Yes.

16 Q. On nutrition, tolerated 80 cc's
well.

17 A. Yes.

18 Q. And the reference to SMA is
19 a reference to standard infant formula feeding?

20 A. Correct.

21 Q. I.V. therapy maintained.
Elimination: didn't eliminate. Urinary output good.
22 Post lasic administration --

23 A. Yes.

24

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D.12

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2 Q. -- bagged for C and S urine.

3 A. Yes.

4 Q. Do you see anything in that note,

5 Doctor, which enhances the warning signal which you
consider to have been in place the day before?

6 A. Again I would be concerned with
7 a comment of pallor or pale. Again this would suggest
8 that the baby's cardiac output is marginal and that
9 would be why he is pale. So again I think it is
10 ongoing concern that I would have as I read this chart.

11 Q. That at that stage is a concern,
12 Doctor, you would have notwithstanding the indication
13 in the progress note that the urinary output was good
14 after the administration of lasix?

15 A. Well, again, Miss Cronk, I think
16 that just means he was getting enough blood by his
17 kidneys to pee. When you give a baby lasix, I think
18 unless the baby is so critically ill and shut down
I would expect this baby to pee.

19 Q. If we look to the further note
20 again on Saturday the 25th, Doctor, we see that his
21 colour remains pale and his output is again described
22 as good. His signs, vital signs are again described
23 as stable. He is playful, he is tolerating feeds.
24 He is tolerating restrictions; I.V. was infusing well,

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2 his condition was described again as stable and
3 unchanged and the plan was to continue present
4 monitoring. That is the end of the evening of the
5 Saturday, 26th of June - of July, I am sorry, Dr.
6 Freedom. Again do you see anything in that later note
7 which is of significance by way of alarm to you in
the condition of the child?

8 A. Just as I have indicated already;
9 ongoing pallor in a baby with aortic stenosis must
10 mean marginal cardiac output. And if the output to
11 the body is marginal, it also means that the blood
12 delivered to the heart muscle is suboptimal. So
13 again I think that would just raise ongoing concern
14 to me as to the apparent well-being of this infant.

15 Q. Well, if we examine the notes
for the Friday and the Saturday together, Dr. Freedom --

16 A. Yes.

17 Q. May I suggest to you that the
condition which you have indicated has some significance,
18 that is the indication of slight cyanosis on the 25th
19 following admission, is a condition which continues
20 through Saturday the 26th. The notation is that the
21 child is pale and remains pale. But beyond that that
22 other than the consistency of that symptom there does
23 not appear to be any dramatic deterioration in the

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D.14

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2 condition of the child from when it was noted on the
3 evening, on the Friday evening. Would you agree with
4 that?

5 A. Partially, in the sense that this
6 baby required intermittent lasix to maintain quote
7 the superficial feeling of well-being, so I think if
8 you look at the numbers per se, you know, the heart
9 rate and the respiratory rate, there does not appear
10 to be a dramatic change, but again the baby required
11 lasix suggesting that the baby's heart failure was
12 worse and that is what would account for the relative
13 stability.

14 Q. The lasix of course had been
15 prescribed the evening of admission, had it not,
16 Doctor?

17 A. Right.

18 Q. And it merely was continued
19 throughout the next day?

20 A. Correct.

21 Q. And one of the purposes of
22 administering lasix is indeed to improve the urinary
23 output of the child and the condition of his heart
24 failure?

25 A. Lasix - first of all, you are
right, Miss Cronk, but lasix in itself is a drug that

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2 we use in the sicker babies. We would often put a
3 baby on aldactazide as a first type of diuretic. If
4 we considered a baby quite ill we would use a more
5 potent diuretic such as lasix. So the fact that they
6 put the baby on lasix on Friday and continued on
7 Saturday would be to me a concern that this baby was
8 very marginal and needed a more potent form of
diuretic.

9 Q. And if we look at the progress
10 notes for the next day, Doctor, July 27th, we see that
11 the child had one episode of vomiting at 12:10 a.m.;
12 heart rate was approximately 120 plus. At 1:10 he
13 was noted to be regurgitating.

14 If we turn to the next page there is a
15 summary of the course of the child; an indication that
16 he had been started on digoxin and diuretics, and that
his congestive heart failure was markedly improved.

17 "Today he was stable, fed well, vital
18 signs stable."

19 And then an indication - I can't read the signature,
20 Dr. Freedom, but I take it to be by the resident
21 cardiologist called to examine the child that he was
22 notified that morning (that is the 27th of July) that
the child was having an irregular pulse; the baby
23 appeared somewhat pale but was alert and did not appear
24

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distressed. He was in sinus rhythm with a mild tachycardia. Blood pressure was normal.

4 At that stage, Doctor, his rhythms
5 appear to be satisfactory. Would you agree?

A. Right.

7 Q. The child's condition overall
was stable?

A. With the caveats that I have
already suggested.

10 Q. And similarly proceeding further:
11 "However shortly thereafter his heart
12 rate declined and his rhythm became
13 irregular. Seconds later he arrested.
14 CPR was initiated immediately. However,
15 this failed to return spontaneous
16 respiration or cardiac activity.
Respiration was terminated ..." "

17 I take that to be approximately one hour after arrest?

18 Would you agree with me, Doctor, in the
19 context of the otherwise stable condition or at least
20 consistent condition described for the child that that
 turn of events was a rather dramatic one?

A. I think it was a sad one.

22 Q. Would you agree, sir, that the
23 decline of the heart rate at that stage when the



D.17

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2 doctor's original examination disclosed vital signs
3 to be stable and its monitoring to be regular was a
4 sudden turn of events?

5 A. Yes.

6 Q. And if we turn to your second
7 reporting letter to Dr. Conner found at page 0, as it
8 happens, of the record, the beginning of the record,
9 Doctor, you describe in the first paragraph a discussion
10 that you held apparently with Dr. Connors on the
morning of the 28th of July and you then state:

11 " ... this infant unexpectedly
12 sustained a cardiac arrest early in the
13 morning of July 27th and could not be
resuscitated."

14 Again, Doctor, can you help us as to what you meant
15 when you referred to the death and the arrest of this
16 child as being unexpected?

17 A. I used the term "unexpected" in
the context of unanticipated.

18 Obviously on Friday afternoon if we had
known this baby would arrest over the weekend I think
20 we would have marched ahead, done the catheter and
21 surgery, but those of us that reviewed this youngster
22 anticipated that the baby would survive the weekend on
23 medications and we were wrong.

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Q. I take it then, Doctor, that the point in time when the child died, having regard both to the examinations that you conducted on Friday, the consensus of opinion which you have described that it was preferable to allow the child to wait until Monday before catheterization was undertaken, that coupled with the events, the terminal events described in the progress notes of the child were all suggestive to you that he died at a time which would not have been anticipated?

A. Again I think this baby had very severe aortic stenosis. The year before I saw this youngster, Dr. George Trusler and I had reviewed our experience with aortic stenosis in babies, and I believe we had an overall 70 to 80 per cent mortality no matter what we did in the first six months of life. Again when I saw this baby on the Friday we had hoped it would survive. I guess I am known among the cardiology circles as more of a "hawk", I have often gone for early intervention, and I was often outweighed, so to speak, by my colleagues like Dr. Rowe who have seen more than I have.

The discussion that came up on Monday was perhaps we should have done it earlier for the



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exact reason that I have mentioned, that these
babies can die suddenly, they do it without warning,
and that is the way babies with severe aortic stenosis
die.

So to get back, it was sad that this
baby died. I am sorry that I hadn't pushed harder
to have something done on Friday night or Saturday
morning. At least to make concern known on Friday
afternoon. I use again the term "unexpected" in the
sense I didn't anticipate he would die, I had hoped
he wouldn't and I was unfortunately wrong.

Q. Do you recall, Dr. Freedom,
speaking directly with Dr. Connors on the morning of
July the 28th reporting upon the child's death?

A. I don't recall specifically
except for my letter where I said "as we talked",
so I presume I called him.

Q. Do you remember, Doctor,
whether or not you expressed surprise to Dr. Connors
that this child had died in the manner and at the
time that he had?

A. I don't think I would - I
can't recall specifically, but knowing what this
baby had both clinically, having seen the autopsy,
where the disease was even more severe than we had

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clinically anticipated, again I would have indicated
more disappointment and concern as opposed to surprise.
I can't recall my exact emotions when I spoke to
Dr. Connors.

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Q. Could you look, Doctor, as
well at the concluding paragraph of your final
reporting letter to Dr. Connors, you indicate:

"In summary then, I think that this
youngster fell into the continuum of
patients with a hypoplastic left heart
syndrome, although certainly his
mitral and aortic valves and his left
ventricle were better developed than
some. I think it would have been most
unlikely that this baby would have
survived aortic valvotomy, and in view
of the thickened fleshy dysplastic
aortic valve with minimal commissural
fusion, I think it would have been
difficult to accomplish much at surgery."

Surgery was a consideration that was
discussed on the Friday of his admission however I
take it, Doctor.

A. Definitely.

Q. And with respect to your



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description of the anatomy of the child and the
type of plastic left heart syndrome at the time of
dictating this letter that you observe the gross
autopsy of David Taylor.

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A. Yes, I had.

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Q. You have indicated I believe
in your response to my question a few moments ago,
that you felt that the post mortem, the gross
autopsy demonstrated a more serious condition than
you previously felt to have existed?

5

A. Correct.

6

Q. Can you help me, Doctor,
specifically in what way was the condition more
serious than that you had originally anticipated?

7

A. When I initially saw this
baby on Friday, his electrocardiogram demonstrated
left ventricular hypertrophy and the so-called strain
pattern. When one sees a baby with severe impedance
to systemic blood flow, aortic stenosis, the STT
segment changes in the cardiogram can suggest that
the lining of the heart, the endocardium is very
abnormally thickened. Now, we try to ascertain
that from our echocardiogram, and the echocardiogram
wasn't supportive either way.

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I think certainly if I was convinced

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before surgery that this baby had severe endocardial
fibroelastosis I would have been even more pessimistic
in my first letter to Dr. Connors.

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THE COMMISSIONER: Pessimistic

about what, Doctor?

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THE WITNESS: I would have said that

most likely nothing we would do for this baby, in
either a medical or surgical way, could alter the
outcome. However, we thought that the baby did not
have severe endocardial fibroelastosis, or at least
I thought he didn't, and at the autopsy table the
baby had a much smaller left ventricle than I thought
clinically. The endocardium was extremely abnormal,
very thickened, yellowish, and it has been our
experience that babies with aortic stenosis and
endocardial fibroelastosis just don't survive
intravention. So the autopsy showed even worse
disease than I anticipated. It would have made it
unlikely that this baby would have survived surgery.
Again I think that it fell to the continuing of the
so-called hypoplastic left heart syndrome.

Q. Dr. Freedom, Dr. Rowe in his

testimony expressed the opinion that a diagnosed
condition of endocardial fibroelastosis in a child
was a condition that was recognized to be, in his



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view, a pre-disposing factor to digoxin intoxication.

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Is that a view with which you concur?

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A. I think there are basically two types of endocardial fibroelastosis, Miss Cronk.

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There is the type that occurs in the absence of other underlying congenital heart disease, so-called EFE in isolation. Then there is the pattern of EFE endocardial fibroelastosis associated with severely pressure loaded ventricles.

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I would be more concerned that it would be the pressure loaded ventricles with EFE that would be more pre-disposed to digoxin intoxication.

Q. Doctor, prior to this child's death, is it your recollection that endocardial fibroelastosis was the condition which was suspected in the child?

A. It is impossible not to suggest that it could be present in any infant with aortic stenosis in this age group.

Q. Was there anything particular to this child's condition at the time he presented on July 25th when you personally observed him, to suggest that might be in reality the case with this child?

A. Well, there were two factors



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that we considered. One was the cardiogram showing the ST segment changes before the baby had been given digoxin, which suggests that it might have been present. And two, on the echocardiogram, if I remember correctly there was a suggestion that the endocardium appeared somewhat bright. Again this has been suggested as a feature of EFE.

Q. Doctor, we know that this child was prescribed and administered digoxin.

A. Correct.

Q. While in the Hospital, but to my knowledge however no digoxin level was ordered in respect of the child. Are you aware of any digoxin level that was obtained?

A. No, I am not.

Q. Dr. Freedom, in respect of the clinical suggestions of the possibility of existence of endocardial fibroelastosis that you have described on the 25th and the 26th of July, would you agree with me that it might have been a prudent thing to order a digoxin level to determine whether or not the possibility of toxicity was evidenced in this child?

A. No, I would disagree with that.



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Q. From your experience, Doctor, when you have cared for and observed patients where you feared or knew that the patient was suffering from endocardial fibroelastosis, is that a matter which you relate to a concern about digoxin toxicity?

A. Our unit in particular is very low on digoxin dosage, both in terms of total digitalizing dose and on maintenance levels. I would have thought that a digoxin level should have been done the following week after the baby was digitalized.

Q. Do you recall, Doctor, on the 28th of July, the morning after this child's death, whether or not you were present at the cardiology conference on the ward at which his death was discussed?

A. I can't remember in particular, Miss Cronk, except unless I am on holiday or out of town for meetings that morning conference is very important, and it is rare that I have ever missed one.

Q. Can you help me with this, Dr. Freedom. Do you recall whether either prior to the completion of the autopsy on David Taylor, or subsequent to the completion of the autopsy, there was any suggestion raised amongst any of the cardiologists or the nursing staff, as to the possibility of



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digoxin intoxication as a contributing factor, or as
an explanation for the death of this child?

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A. The only time that was called to my attention was I think either by you or Mr. Lamek in preliminary discussions, where it was raised that the nurses had kept a log book and that was at our first meeting.

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Q. Are you saying then, Doctor, that after this child's death, throughout the many months that followed digoxin intoxication, to the best of your recollection it was not raised at least you have no knowledge or recollection of it having been raised prior to your discussions during these proceedings?

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A. Correct.

Q. With respect to David Taylor?

A. Correct.

Q. I take it then it was not something that you considered as a possible contributing factor or explanation for his death?

A. That is correct.

Q. Did anything in the pathology results after the final autopsy was completed, Dr. Freedom, lead you to alter or amend your opinion as to the probable cause of his death as you have



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Freedom, dr.ex.
(Cronk)

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described it?

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A. No, I believe the autopsy findings supported my feeling as to why this youngster died.

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MS. CRONK: Mr. Commissioner, I am about to move on to the next child. Would now be an appropriate time?

9

THE COMMISSIONER: All right, we will take 20 minutes then.

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MS. CRONK: Thank you, sir.

11

---Short recess.

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--- Upon resuming:

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MS. CRONK: Q. Dr. Freedom, the next child who died was Amber Dawson on the 20th of July, 1980. Once again, based on your earlier evidence and my only review of the medical records, as I understand it, you had no direct involvement in the care and management of this child. Is that correct?

8

A. That's correct.

9

Q. In sequence then, Doctor, the next child to die on the cardiology wards was Lillian Hoos. That record, Mr. Commissioner, is Exhibit No. 60. Mr. Registrar, does the witness have copies?

10

THE COMMISSIONER: Yes.

11

THE WITNESS: Yes, I do.

12

MS. CRONK: Q. That child, Dr. Freedom, as I understand it, was admitted to the Hospital for Sick Children on the 16th of July, 1980?

13

A. Yes.

14

Q. On the first day of her life. She died approximately two weeks later on July 31st?

15

A. Okay.

16

Q. At birth, as I understand it, Doctor, she was noted to be cyanosed, noted to have a heart murmur and to have a single umbilical artery. Was this child in the first instance referred to you, Dr. Freedom?

17



F.2

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2 . A. I do not believe so.

3 Q. All right. As I understand it,
4 however, on July 17th, the day after her admission,
5 you performed a cardiac catheterization on her?

6 A. That's right, Miss Cronk.

7 Q. And if we turn to page 103 of
8 the record, do we find there your report concerning
9 the outcome of the catheter procedure?

10 A. Right.

11 Q. And your final diagnosis, as a
12 result of the catheter procedure, indicates the
13 predominant finding of pulmonary atresia with intact
14 ventricular septum?

15 A. Right.

16 Q. Am I correctly reading these,
17 Dr. Freedom, that in order of priority the findings
18 are listed under your final diagnosis so that the
19 predominant feature in this case would be pulmonary
20 atresia?

21 A. Correct.

22 Q. All right. And then the balance
23 of your findings, based on the catheter procedure, are
24 set out in that section of your report?

25 A. Correct.

Q. And if we look to page 44 of the
record, Dr. Freedom.



F. 3

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A. Yes.

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Q. This section of the progress

4 reports for July 17, 1980?

5

A. Yes.

6

7

Q. We again see a note, the results
of the cardiac catheterization. Is that your note,
Dr. Freedom?

8

A. Yes, it was.

9

THE COMMISSIONER: I'm sorry, 44 did
10 you say?

11

12

MS. CRONK: Page 44, Mr. Commissioner,

13

14

of the record.

15

16

THE COMMISSIONER: I think we've got

some trouble.

17

18

MS. CRONK: Preceded by four zeroes;

for what purpose I can't help you, Mr. Commissioner.

19

20

THE COMMISSIONER: No. Well, I have

from 41 to 65 but it may go backwards. Oh, yes, I sec.

21

22

I don't know, 44 is between 45 and 43 but it is in the
wrong order.

23

24

MS. CRONK: Do we have it now, sir?

25

THE COMMISSIONER: Yes.

26

27

MS. CRONK: Q. That is the note

28

29

directly in the progress notes, Dr. Freedom, again by
you reporting on the results of the catheter procedure
as I take it?

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F. 4

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2 A. Correct.

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Q. And as I understand it, in

addition to the normal catheter procedure a balloon septostomy was performed on this child on the 17th of July?

A. Correct.

Q. And you conclude, you repeat the findings of the catheter study that are set out in your catheter report that we looked at a few moments ago and, in addition, you have included the notation "Will discuss with parents and CV cardiovascular surgeons, plans for surgery"?

A. Correct.

Q. Can you help me, Dr. Freedom, was it intended this child be operated on in the near future?

A. Yes. I think this baby had no direct connection between the heart and the lungs, was being maintained on a medication called prostaglandin and would certainly require surgery.

Q. All right. And in fact, Dr. Freedom, again based on my review of the record, she in fact did proceed with surgery on the next day, on the 18th of July, for a Waterston shunt, and we see a notation of that on the progress notes on page 45?



F. 5

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2 A. Correct.

3

Q. Following that, am I correct,

4

Dr. Freedom, that she was admitted to the ICU?

5

A. Yes, from the chart that is
correct.

6

Q. Are you familiar with the progress
notes in the record for this child, Dr. Freedom?

7

A. No, I am not.

8

Q. Did you have an opportunity
following her death to review the record in its
entirety?

9

A. No, I have not.

10

Q. Well, perhaps if I could briefly
then summarize her course following admission to the
ICU and based on your understanding of the child's
history, perhaps you could tell me if in any way the
summary is incorrect?

11

As I understand it, based on previous
evidence after her admission to the ICU ---

12

THE COMMISSIONER: No, no, just a
second, Miss Cronk. It is going to be very difficult
for the witness, is it not, if you summarize the
progress and without his actually reading the report?

13

MS. CRONK: Quite right, Mr. Commissioner,
perhaps I should go at it a different way.

14

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F. 6

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2 THE COMMISSIONER: Well, I was wondering
3 if perhaps you shouldn't go at it at all.

4 MS. CRONK: And that may well be true,
5 sir.

6 THE COMMISSIONER: Yes.

7 MS. CRONK: With your indulgence for
a moment.

8 THE COMMISSIONER: Yes, all right.

9 MS. CRONK: Q. Dr. Freedom, you have
10 told us that you did not have an opportunity to review
11 the progress notes in detail. Were you present at
12 the cardiology conference which was held the day
13 following the death of this child?

14 A. Again, Miss Cronk, you asked me
that and the others and I presume I was. I can't
15 remember if - this was in July, was it?

16 Q. That's right.

17 A. I know I took holidays some time
in July. Obviously I was there for the catheter study
18 but I just can't recall specifically if I took part in
19 that conversation.

20 Q. All right. Doctor, following the
catheter study itself then, do I take it that you have
21 no specific knowledge as to the course of this child
22 in the Hospital?

23

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F. 7

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A. Correct.

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Q. All right. You did however, as

I understand it, report upon the child's catheter study to the referring physician, Dr. Chung, at page 3 of the record?

A. Correct.

Q. I have been unable to find a final reporting letter, Doctor, in respect to the death of this child. Can you help me, are you aware as to whether or not a final reporting letter was done in respect of this child?

A. I don't have one, I didn't do one.

The operating procedure is that the fellow in cardiology, in this case Dr. Ning, would write a letter to the referring physician with my name undersigned supervising the catheter study. So, I do remember this letter, this is based solely on the catheter study performed July 17th.

Q. All right. Now, subsequently, Doctor, following the death of the child, do you recall whether or not you were present for the gross autopsy of Lillian Hoos?

A. I don't recall.

Q. Do you recall whether or not you at any stage observed her heart following death?



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A. I probably did because, again, I tried to look at all the hearts of the children that have gone on to autopsy at Sick Children's, but I can't remember specifically, Miss Cronk, if Baby Hoos was one of those.

Q. Do you recall today, Dr. Freedom, based on what you have described as your limited involvement with the child and your non-involvement essentially following the catheter procedure as to whether or not you were invited to or did form an opinion as to her probable cause of death following the event of her death?

A. I can't recall specifically.

Q. All right. Well, perhaps then, Mr. Commissioner, we will move to the next child.

THE COMMISSIONER: Yes, all right, thank you.

MS. CRONK: Dion Shrum.

Q. I take it, Doctor, that you did have direct involvement in the care and medical management of this child?

A. Dion Shrum, yes, I did.

MS. CRONK: That record, Mr. Commissioner, is Exhibit 53.

Q. Dr. Freedom, again, to summarize



F.9

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2 the key events with respect to this child, as I under-
3 stand it he was admitted to the Hospital on August 8,
4 1980 and died the next day on August 9th at approxi-
5 mately 7:45 p.m.?

6 A. Yes.

7 Q. Were you the cardiologist on call
at the time this child died, Dr. Freedom?

8 A. Yes, I was.

9 Q. And if we deal for a moment,
10 Doctor, with the manner in which the child presented
11 at the time of admission, as I understand it, he was
12 approximately two months of age, a murmur had been
13 noted approximately one week prior to admission and
14 he had been diagnosed at the referring hospital to be
15 in congestive heart failure. Does that accord with
16 your recollection?

17 A. Yes, it does.

18 Q. And a chest X-ray was performed
19 on the night of his admission, and this disclosed, as
20 I understand it, an enlarged heart and hyperinflated
21 lungs and was admitted directly to the ward from the
22 Emergency Department and you I gather then saw him
23 the next morning and made a note of that consultation?

24 A. Correct.

25 Q. Which we find at page 46 of the
record?



F.10

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A. Correct.

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3 Q. Is that your note of the

4 examination of the child?

5

A. Correct.

6

MS. CRONK: I think this record, as well,

7

Mr. Commissioner, has regrettably some pages out of
order, but that's found at page 46.

8

THE COMMISSIONER: Yes, all right.

9

MS. CRONK: Q. I'm sorry, Dr. Freedom,
10 that is your note of your consultation on the 9th of
11 August?

12

A. Yes, it is.

13

Q. All right. And you summarize your
impression of the child's condition half way down your
note as "pale, sallow, tachypneic, dyspneic, infant
receiving supplemental oxygen by hood, not cyanosed
at that stage". Is that correct?

17

A. Correct.

18

Q. All right. You also indicate
that your impression at the time was of hypertensive
ventricular septal defect. Am I reading that correctly?

21

A. Correct.

22

Q. In severe congestive heart failure?

23

A. Correct.

24

Q. Can you help me with the balance

25



F.11

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2 of your note, Doctor, under the impression?

3 A. Where it says arrow rule out?

4 Q. Yes.

5 A. "Total anomalous pulmonary
6 venous draining",
and then the next rule out is:

7 Q. "Rule out truncus arteriosus".

8 A. And if we turn to the next page
9 of your consultation note, Dr. Freedom.

10 A. Yes.

11 Q. Your commentary is that the baby
12 was very ill, was in congestive heart failure with
13 findings, I take that to be of severe, is that
14 preliminary?

15 A. Pulmonary.

16 Q. Pulmonary hypertension. The most
17 likely diagnosis is hypertensive ventricular septal
defect?

18 A. Yes.

19 Q. Although there is a good - can you
20 help me?

21 A. Although there was a loud ---

22 Q. I'm sorry?

23 A. --- apical click and narrowly
24 split S2. The diagnosis of truncus is unlikely,
et cetera.

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F.12

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Q. All right. And your plan as recorded on the balance of the consultation note was to treat the child with digoxin, diuretics and oxygen?

5

A. Yes.

6

Q. And that a catheterization would be performed either Sunday or Monday, is that correct?

7

A. Correct.

8

Q. And that note I take it, Dr. Freedom, was made at approximately 7:30 a.m. following your examination of the child at 7 o'clock on the day of her death?

11

A. Right.

12

Q. The progress notes don't really assist us a great deal in this case by virtue of their brevity, Dr. Freedom. Are you familiar generally with the progress of the child following your examination of the child that morning?

17

A. Well, correct. This youngster had come in, as you know, the evening before. I had seen him early that morning and I would have hoped that Dion would have responded to the anticongestive therapy but in fact the baby was actually in more distress later that morning.

22

Q. And the child was in fact taken to the Cath. Lab, as I understand it, the following day?

24

25



F.13

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A. I would have to see my calendar.

2

I wrote my progress or my consultation note ---

3

Q. I'm sorry, Dr. Freedom, to assist
you.

4

A. ... on the 9th of August.

5

Q. I am sorry, to assist you, I think
the catheterization was performed that afternoon?

6

A. It was.

7

Q. The afternoon of the 9th, not the
next day?

8

A. Right.

9

Q. And judging from the consultation
note you had originally anticipated that the process
would be undergone either the next day or the Monday.
Can you help me as to what events occurred in the
progress of the child that prompted the catheter
procedure to be carried out that afternoon?

10

A. Yes, the baby, despite medications
and supplemental oxygen was even in more distress. The
baby had a louder gallop rhythm, was showing more
signs of respiratory distress and I felt that we
should get on with it.

11

Q. If we turn to page 4 of the record,
Dr. Freedom, I take that to be your reporting letter
to the referring physician dated August 13th following
the child's death?

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2 A. Correct.

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Q. And I would refer you to the

second main paragraph of your letter and what I take to be a description by you of the disclosure or the diagnosis made following the catheter study?

A. Correct.

Q. Can you highlight for us very briefly what the results of the catheter study demonstrated?

A. Yes. This infant had a condition called total anomalous pulmonary venous return. This condition is characterized by the reality that the four lung veins bringing red blood back to the heart joined to the right side of the heart. In addition, for survival, this baby had to have a communication between the two upper chambers of the heart, which Dion did. This is a so-called atrial septal defect, but because it was somewhat small we did a balloon septostomy.

Q. All right. And I take it from the contents of your reporting letter to Dr. Patel that the catheter procedure in your view, despite those findings, was in fact tolerated well by the child?

A. If I recall, Miss Cronk, the baby did have an episode of bradycardia, maybe one or



F.15

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2 two episodes, during the catheter procedure. I believe
3 I dictated that in my catheter note.

4 Q. All right. Perhaps to help you
5 as well, Dr. Freedom, if I could refer you to page 27
6 of the record, which is part of the discharge report
concerning Dion Shrum.

7

A. Yes.

8 Q. There is the indication that
9 during the procedure, that is, the catheter procedure,
10 the child became bradycardic momentarily on two
11 occasions, however, responded without intervention and
12 left the catheterization lab stable in sinus rhythm
13 with a normal blood pressure.

14

Does that description accord with
your recollection of the events in the Cath. Lab?

15

A. Yes, it does.

16

Q. Yes. So, I would take it then
that despite the two episodes of bradycardia while
before or during the catheterization procedure - do
you recall?

17

A. I think it was during.

18

Q. All right. That despite those
two episodes, medical intervention, I take that to
mean either medication or other resuscitative
procedures were not necessary?

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F.16

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A. Correct.

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Q. And that by the time the

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procedure had been completed the child's condition
was relativoly stable, normal electrical activity is
at sinus rhythm with a normal blood pressure?

4

A. Correct.

5

Q. And if we turn again to the

6

progress notes, Dr. Freedom, to page 40, it appears
that after Dion Shrum was returned to the ward that
his condition did not vastly improve - I am referring
to the progress note at the bottom of page 40 made on
the 9th of August.

7

A. Correct.

8

Q. The child was still tachypneic
at ...

9

A. 72.

10

Q. ... 72 per hour. pulse was 160.

11

A. Excuse me, 72 per minute.

12

Q. Per minute. 72 per hour would be
a gross condition?

13

A. Yes.

14

Q. Pulse was 160, the blood pressure
was 75. If we continue through the notes of the 9th
on to the next page we find a description of his
condition when he returned from the Cath. Lab as being

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F.17

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2 rather pale and irritable, respirations were shallow,
3 the apex was bounding, and then an indication by the
4 author of the note that:

5 "We spoke with Dr. Freedom and were
6 told baby's --- "
7 I'm sorry.

8
9
10 "Parents' visiting at this time,
spoke with Dr. Freedom and were told
the baby's prognosis but parents were
in disbelief."

11 Do you recall speaking to the parents
12 of Dion Shrum following the catheter study that had
13 been conducted earlier that day, Dr. Freedom?

14 A. Yes, I do.

15 Q. Do you have any present
16 recollection as to what your prognosis was at that time
for this child?

17 A. I told them that the baby would
not survive without surgical intervention and that
surgery for this condition carried a relatively high
risk.

18 Q. Was surgery being planned in the
near future for Dion Shrum at that stage?

19 A. Yes.

20 Q. And if we refer to the balance of

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F.18

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2 the progress note on page 41, Dr. Freedom, we see the
3 notes for the late night shift 1630 to 1845 hours,
4 the child was gagging, was very irritable and hard to
5 settle, became quite diaphoretic and apex was still
6 bounding, respirations grunty and baby appeared to be
7 in severe distress, Dr. Goldman was informed, pupils
were dilated. Moving down to the note at 1845:

8 "The baby was in severe distress and
9 the apex became very irregular, Code 23
10 was called for Dr. Schaffer, apex was
11 fluctuating between 140 and 90, baby
12 started to have seizure-like activities
13 with eyes rolling back and body became
14 very rigid, respirations ceased and
15 apex fell below 50 and Code 25 was
16 placed, cardiopulmonary resuscitation
17 was started, see physician's note for
18 further treatment."

19 The baby was pronounced deceased at
20 1945 by Dr. Schaffer.

21 Were you present, Dr. Freedom, during
22 the cardiac arrest and the death of this child?

23 A. No.

24 Q. Did you, after the child's death,
25 have occasion to discuss the manner and the mode of



F.19

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2 the child's terminal events and cardiac arrest at
3 the cardiology conference which followed the next day?

4 A. We had several conversations,
5 Miss Cronk. I was there the afternoon after the
6 catheter study. We had asked for people from the
7 Intensive Care Unit to come up and review this child
8 with us. It was my feeling at that time that perhaps
9 the baby would do better with respiratory support in
10 the Intensive Care Unit. That was not done. I
11 believe the Intensive Care Unit felt that we should
12 march on in the cardiac ward. The discussion the
13 following day concerned again that issue, would this
14 baby have done better with a ventilatory support over-
15 night because of the severe respiratory distress;
16 No. 2, the question came up, should this baby not only
17 have been put on the ventilator but paralyzed.

18 Q. All right. Well, Doctor, if we
19 can take that in stages. We know that you saw the
20 child at 7 a.m. on August 9th and made a written
21 recording of your consultation with him at that time.
22 Do you recall when your discussions were held with the
23 ICU?

24 A. It must have been subsequent to
25 the catheter procedure when we had made the diagnosis
26 of the anomalous venous connections.



F. 20

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Q. All right. And was it your view
at that stage that the child should be admitted to
the ICU?

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A. I certainly had a concern and I
wanted the ICU people to see this baby and to get
their input into the discussion.

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Q. Dr. Freedom, we have heard from
Dr. Rowe evidence that again suggests that as a result
of your discussions with the ICU, that it was felt
that the child should stay on the ward and the child
was not admitted to the ICU. In the normal course of
events, Dr. Freedom, if you were of the view that a
patient should be admitted to the ICU because of an
existing condition or because of any change or
deterioration in condition and had a discussion of that
kind with the ICU, is that a matter that you would
wish to see recorded in the record of the child?

-



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A. I think ideally it should be.

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Q. Can you help me, Doctor, and fairly there is no indication in the record that that discussion was held, but I take it your evidence is that you recall having had such a discussion and the decision was reached that the child should remain on the ward?

9

A. Correct.

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Q. Can you help us, Doctor, as to why the decision was reached that the child should remain on the ward if you had concerns that you indicated you had?

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A. Again I think that any baby in severe respiratory distress could potentially benefit from the intensive support of ventilation. I would presume it was felt by the Intensive Care Unit individual that he felt this baby at this point in time did not require respiratory support. And again for that reason the child was not taken downstairs.

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Q. It wasn't a question of available space or anything of that kind and it was just a question of the ICU assessment of the child's condition?

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A. I can't -



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unfortunately I can't remember whom that
was addressed to in terms of the ICU, but it was
my recollection that while the baby was not retaining
carbon dioxide immediately let's hold off.

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Q. Was there any discussion later
in the evening, Doctor, after your initial consulta-
tion with the ICU as to whether or not at that point
later in the day the child should be admitted to the
ICU?

A. Well again we did the
catheter study in the early afternoon so we finished
a couple hours later, and the baby arrested at - just
a few hours after that. So my recollection is that
we talked to the ICU folks late that afternoon and
then it was just a few hours later that the baby went
into arrest.

Q. In the description of the
terminal events and the condition of the child on
return to the ward, Dr. Freedom, bearing in mind
that when the child left the cath lab despite those
two brief episodes of bradycardia, would you agree
with me that the onset of irritability and irregular
apex, difficult respirations, dilation of the pupils
appear to have been events that set in very quickly?

A. No. Again I wouldn't agree



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3 with that. This baby was grievously ill from the
time I saw it.

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with that. This baby was grievously ill from the
time I saw it.

I described the baby as being

severely ill, breathing hard. The blood pressure
that I recorded on my note of 0700 was 95, and that
afternoon after the progress the blood pressure was
already down to 75. So I think already there was
ongoing deterioration from a babe who was already
very ill.

Q. Did you personally see the

child after its return from the cath lab?

A. Yes, I did.

Q. Was that subsequent in the day

or do you recall whether it was prior to the cardiac
arrest?

A. No, and I have already said,

Miss Cronk, I had seen the baby after the catheter
study. I had spoken with my fellow getting ICU up
there to see the baby. I can't remember the exact time
framework but it was after the child came back from
the catheter lab. But again I was speaking to the
family.

Q. During the course of your

examining the child after its return from the cath
lab, Doctor, did you observe any symptoms that are



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later described as having occurred in the early
evening prior to the child's arrest?

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A. Well again I thought the baby
was severely distressed and that is why I suggested
that we get the ICU opinion as to whether or not this
infant should be downstairs and ventilated.

8

9

Q. Do you recall whether or not
the apex of the child was irregular at the time you
examined it on its return to the ward?

10

A. I can't recall.

11

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Q. Do you have any recollection
about whether or not its respirations were irregular
or whether they were difficult, whether he appeared
to be stable at that time?

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A. No. I think that certainly
this baby's respiratory pattern was extremely laboured.
The type of malformation that this baby has or had
causes a terribly severe lung congestion. So as I
read the notes and saw this baby, the baby was already
relatively hypotensive. The blood pressure had come
down. The respiratory rate was still very high, so
I think this baby was deteriorating, and that is what
prompted me and my concern for the ICU.

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25

Q. Doctor, would you turn with me
to page 4 of the record again, your reporting letter



G5

1
2 to Dr. Patel.
3

A. Yes.

4 Q. At the conclusion of your
5 description in the second paragraph of the outcome of
6 the catheter study you indicated with respect to
7 the catheter study that he tolerated the procedure
8 without incident, but approximately seven hours
9 after the catheter study, suddenly became profoundly
10 bradycardic, sustained a cardiac arrest and was not
able to be resuscitated.

11 A. Yes.

12 Q. Can you help me, Doctor, if
13 you felt his condition was sufficiently serious from
14 the moment of the first examination through the
15 conduct of the catheter procedure and throughout his
16 stay on the ward why you described at that stage his
17 bradycardia as having had a sudden onset?

18 A. Well again the heart rate
19 change was relatively sudden from a rate of 160, but
20 the deterioration was certainly going on over that
period of time.

21 Q. And the child in fact you
22 previously noted at the time of leaving the catheter
23 lab was relatively stable and his blood pressure was
normal.

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A. Yes, but again some hours later
it was not normal.

Q. Dr. Freedom, were you present
at the gross autopsy of this child?

A. I remember, Miss Cronk, seeing
the baby's heart and lungs. I can't remember viewing
the remainder of the autopsy.

Q. Do you recall whether or not
you saw the heart and the lungs shortly after the
child's death or was that some time subsequent,
several days subsequent to death?

A. I just can't remember. Let's
see, the baby died on the 9th, was it, that afternoon --

Q. That is right, Doctor.

A. And my letter was dictated
August 13th, so I just can't place into a time frame-
work when I viewed all this.

Q. Doctor, is it a normal matter
if you were not able for whatever reason to be present
at the gross autopsy of the child, would the Pathology
Department retain for you the heart and if necessary
or requested by you the lungs of a cardiac pediatric
patient for your later observation?

A. They could not do that unless
the family had given consent for retention of organs.



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3 So whether or not I had requested it is really
4 incidental.

5

6 Q. I assume if the parents were
7 to be consulted with respect to the retention of
8 organs that request might either come from you or
9 from the Pathology Department?

10

A. Correct.

11

12 Q. And in this case do you recall
13 whether or not that is what happened?

14

A. I just can't recall.

15

16 Q. Now having seen at some stage
17 then after the death of the child his heart and his
18 lungs, Doctor, was there anything that you observed
19 in the gross anatomy of the heart and the lungs which
20 suggested to you any difference from what your
21 clinical diagnosis had been as to his anatomical
22 condition?

23

24 A. No. I think the catheter
25 study confirmed or made the diagnosis - this was
confirmed unfortunately at post mortem.

26

27 Q. Did you at that time, Doctor,
28 having observed the heart and the lungs come to a
29 conclusion or formulate an opinion as to the probable
30 cause of death of this child?

31

32 A. Yes. I felt that the baby
33

34



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2 had severe congestive heart failure. To establish
3 unequivocally the diagnosis of these anomalous
4 pulmonary venous connections one has to inject
5 contrast material into the lung artery, and because
6 these children have a torrential lung flow 8 to 10
7 times normal, I think it is well known among those
8 of us who do catheter procedures that such babies
9 may not tolerate the investigation. I felt that the
10 severe heart failure, the stress of any investigation,
11 basically underlying disease was responsible for this
12 baby's death.

13 Q. Doctor, the child as we know
14 had been prescribed and administered digoxin on
15 admission to the Hospital. Death followed a relatively
16 short time thereafter following the catheter study.

17 So far as I'm aware no digoxin levels
18 were obtained in that short period of time. Are you
19 aware of any levels having been taken?

20 A. No, I am not.

21 Q. Doctor, can you help us, do
22 you have any recollection as to any discussion amongst
23 any of the staff cardiologists or any member of the
24 Pathology Department following the death of Dion
25 Shrum as to whether digoxin intoxication might have
been a contributing factor or an explanation for the



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death of this child.

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A. I recollect that there was
no such discussion.

5

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Q. You don't recall any having
happened?

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A. No.

8

9

Q. The next child who died,
Doctor, on the ward, was Kelly Monteith, who died
on August 19th, 1980.

10

11

A. Her record, Mr. Commissioner, is
Exhibit 55.

12

Do you have that, Doctor?

13

A. Yes, I do.

14

15

Q. As I understand it you were
ward chief at the time of Kelly Monteith's death;
is that correct?

16

A. That is correct.

17

18

Q. We know from the progress
note and previous evidence, Dr. Freedom, for August
14th, she was admitted to Ward 4A at approximately
11:30 a.m., having been sent for evaluation because
of cardiomegaly and respiratory distress.

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She was started, as I understand it,
on digitalizing doses and lasix as well as aldactazide.
Is that correct?

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A. Correct.

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Q. Are you familiar in general
terms with the course of this child in the cardiology
ward, Doctor?

5

A. Correct.

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Q. You had an opportunity in the
recent past or at the time of the child's death to
review the progress notes and medical record of the
child?

10

A. Right.

11

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Q. You saw her, as I understand
it, Doctor, at approximately 6:30 p.m. on the ward
and made a note of that consultation on August 14th.
I refer you to page 52 of the record.

15

You recall having seen the child at
that time?

16

A. Correct.

17

18

Q. It is your note of the
examination of the child which then occurred?

19

A. Yes.

20

21

Q. You describe the condition of
the child in your consultation note, Doctor, as:

22

"Pale, sallow, tachypneic, dyspneic
baby."

23

24

You heard faint rales at the left base of the lung.

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G11 Is that both lungs?

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A. No I said left base so it
must have been left base.

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Q. And your impression recorded
on the right hand side of the page at the bottom at
the time, Doctor, was one of anomalous left coronary
artery and mitral - is that incompetence, Doctor?

9

A. Yes, correct.

10

Q. And a huge?

11

A. Left atrium.

12

Q. With bronchial compression.

13

A. Correct.

14

Q. On the left hand side of the
page, Doctor, your prognosis you described as guarded.
Your suggested treatment was digoxin and lasix and
afterload reduction.

15

A. Yes.

16

Q. I take it that is to refer to
a recommended reduction in the amount of digoxin and
lasix following loading doses?

20

21

A. No. It had nothing to do with
that at all.

22

Q. Could you explain it to me,
Doctor?

23

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A. Yes. In children who have a

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severely impaired left ventricle one way to try and
attempt to manage them is to reduce the resistance
against which the heart pumps. So one way to do that
is to reduce the blood pressure and the medical
jargon is afterload reduction to reduce the load of
the work of the heart.

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Q. All right. And was that the

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intended purpose of the administration of the lasix?

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A. Well, no, the child was in

severe heart failure and had had pulmonary edema as
I noted on x-ray findings, and the purpose of the
lasix was to help improve the state of congestion of
this ill baby.

Q. And you told us, Doctor, that

is a drug which in your view should be prescribed and
administered in the more seriously ill patient?

A. Correct.

Q. We have heard from Dr. Rowe

in prior evidence, Dr. Freedom, that the child was
later transferred that evening to the ICU where she
remained overnight, returning to the ward the next
afternoon.

Can you help me, Doctor, in your view

at the time that you examined the child during the
evening of August 14th was she in critical condition?



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A. She was severely ill.

3

Q. Did you participate in the
decision to send her to the ICU?

4

A. I can't recall.

5

Q. I take it that that was an
event that you would have considered appropriate
given your examination of the child?

6

A. Yes.

7

Q. In your view did she require
at that time close monitoring?

8

A. Yes.

9

Q. Was she experiencing respiratory
distress?

10

A. Yes, she was. As a matter of
fact the referring diagnosis from Dr. Verbeek in
Timmins was that this child was thought to have a
major abnormality of the blood vessels compressing
the left lung. And as a matter of fact the phone
conversation I had the diagnosis was vascular ring,
so it came as a surprise to Dr. Verbeek and indeed to
ourselves when we saw this baby to find the reason
for the severe distress.

11

Q. Doctor, as I read the record
after your initial consultation and examination of
the child on the 14th of August you had no direct

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Freedom, dr.ex.
(Cronk)

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involvement in her care although you subsequently attended and participated in a surgical conference on the 18th of August at which time her case was discussed; is that correct?



/DM/ak

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A. No, it is not correct. If

I recall, Miss Cronk, this child had been transferred to the ICU, back up the next day when I was still ward chief.

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Q. And do you recall, can you help us as to what your observations were as to her condition on, that would be the 15th?

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A. Well, I think in general our experience with this lesion in babies who are this grievously ill has been very, very poor. I can't remember whether I stated it to the family, or to the residents, that we had lost almost every patient we had with this condition who presented in this fashion, whether they were treated medically or surgically. So I was certainly concerned about how ill this baby was.

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Q. You said, Dr. Freedom, that

your general impression with patients with this kind of condition as you have described it, was that as well the state of condition which you felt to apply on the 15th when you saw her?

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A. Yes. Other than being dead I felt that this child's heart was so badly damaged, and her left upper chamber, left atrium and left ventricle was so huge that is what accounted for the



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compression of her lung. So I think the shorter answer is yes, I was very concerned about the viability of this baby.

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Q. Can you tell me then, Doctor, her condition was regarded by you with that degree of severity, why she was not kept in the ICU longer than overnight?

9

A. No, I can't respond to that. I can't remember the exact discussion.

10

11

12

Q. Do you have any recollection of recommending that the child be kept in the ICU longer than overnight on the 14th?

13

14

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16

A. Again I think, Miss Cronk, there are several considerations that go into keeping a youngster in the ICU. This baby was not being ventilated, that is it didn't have a tube through its airway.

17

Q. Yes.

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21

A. And I think perhaps in trying to reconstruct, or trying to remember a discussion, they said, well, you can monitor it upstairs, it doesn't need support of this type here.

22

23

Q. Do you recall, Doctor, that kind of discussion having taken place?

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A. No, I don't.



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Q. Do you recall any discussion whatsoever after the admission of the child to the ICU on the 14th, as to whether or not her stay in that unit should be lengthened?

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A. I can't recall specifically.

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Q. And then I take it, Doctor,

you have told me that you observed the child as you continued to be ward chief, and you thought on the next day, the 15th, did you have occasion to observe her condition again prior to the surgical conference that was held on the 18th of August?

A. Yes.

Q. Can you help us as to what her condition was as it progressed through the 16th and the 17th of August?

A. I think the baby remained very ill with a huge heart, with findings of a leaking of mitral valve, mitral regurgitation. Certainly her electrocardiogram supported this diagnosis of this anomalous left coronary artery, I think we had grave concerns as to what we were going to be able to offer this baby.

Q. Did you make any note in the progress notes of your observations for the next several days of this child, Doctor?



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(Cronk)

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A. No. Until the events of July
1980 to March 1981 I had felt that as a teaching
hospital the notes were better left to my residents
and fellows.

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Q. It would be uncommon then for
you to have, throughout this period of time, made
directly a note in the progress notes of any given
child?

9

A. I would say, Miss Cronk, there
were occasions when I probably put a note in. I try
to be very specific with my consultation notes. But
I did not on a day to day basis when I was ward
chief put progress notes on the charts.

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Q. Could you turn with me,

Doctor, to page 43 of the record, pages 43 and 44,
which are the progress notes of August 17th.

18

First at 7:30 in the morning, appearing
at the bottom of page 43, do you have that, Doctor?

A. Yes.

19

20

Q. The vital signs of the child
at that time were described as:

"Apex 116-134 and regular."

21

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A. Yes.

Q. "Respirations" do you read
that to be 62 to, is it 82 a minute?



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A. That is what I would take it.

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Q. And I have difficulty with the
next word, is it "substernal"?

5

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A. It looks like substernal
retractions noted even when...something low.

7

8

Q. "Colour remained pale and
40 per cent oxygen via hood".

9

10

A. Correct.

Q. And again I have difficulty:
"Became..."

11

12

A. To me it looks like: "Becomes
increasingly..."

13

14

Q. "Cyanosed when out of hood for
feed".

15

16

A. Correct.

Q. And if we observe the next
nursing note on the 17th, at 1900 hours:

17

18

"Vital signs: apex 120 to 170 and
regular.

19

20

Respirations: 42-70 substernal
indrawing when patient upset.

21

22

Nutrition - feeding better today.
Took 100 cc at evening feed with no

respiratory distress."

23

24

And a description of the parents having attended and

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visited, and a short teaching episode with the mother.

3

A. And talked to priest.

4

Q. And talked to priest. Do you
consider that significant, Doctor?

5

A. Yes, I do.

6

Q. Do you draw from that
indication an inference that the parents had been
informed of the seriousness of the child's condition
at that stage?

7

A. Yes, I do.

8

Q. In your view do the progress
notes for the 17th that we have just reviewed support
the view that the child's condition was continuing to
deteriorate?

9

A. I think they show reasonably
good nursing notes as a matter of fact, but again,
as I think you have heard already, there is a
difference in respect to what a physician looks for
and what a nurse looks for.

10

I think that as I read this, again:

11

"Remains pale in oxygen..."

12

And the fact that a baby with this condition becomes
cyanosed, I think it is extremely concerned. Again
a baby with the anomalous left coronary artery
originating from the pulmonary artery has no reason

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to be blue. Yet, if he is blue and taking what you
have read to me, this baby's cardiac output must be
so marginal that caused him to look cyanosed. So I
would say despite looking at the numbers as you have
done 116 and 134, et cetera, this baby was grievously
ill, cyanotic because of an inadequate cardiac output.
Again: "Became blue taken off oxygen", I think with
this type of lesion is a very, very concerned sign.

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Q. Doctor, would you agree with
me, and I accept your description of the child's
condition as you saw it and determined on the 17th.
Would you agree with me that in reading through the
progress notes for August 17th, the severity of that
condition doesn't immediately jump out at you?

A. It may not jump out to you,
but it jumps out to me.

Q. Notwithstanding that the apex,
Doctor, was described twice that day as being regular.
That the respiration, despite the substernal indrawing
when patient was upset seemed not to be of grave
concern at that stage?

A. No, I think you are misreading
it. Because on the note at 0730, at the bottom of
page 43 it says:

"Substernal retractions noted even when
low."



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So here again it makes me think this
baby was distressed even if the respiratory was
relatively low.

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Q. And that seems to have changed
by that evening had it not, Doctor, when the sub-
sternal indrawing was noted to take place or to occur
when the patient was upset.

9

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A. I am not sure, Miss Cronk, to
where you are referring on the top of the page?

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Q. I am referring to the next
page of the progress notes:

"1900 hours, nursing note - August 17."

A. No, I was looking above that
where it says: "extremities very cold". Again to
me with a baby who's cardiac output is marginal it is
like an adult who is in shock. The first thing you
can feel are cool extremities. When you have severe
heart impairment you don't get the blood flow to the
extremities, so again as I read this I would be very
concerned about what is going on.

Next: "Behaviour of babe lethargic".
So what you and I are reading I think it is difference
in perspective.

Q. All right, Doctor. We have
your evidence that in your view based on your



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examination of the child on the 16th and the 17th
the condition was deteriorating at that time.

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A. I would say this Miss Cronk,
it certainly was not showing great improvement and
one would have the concern with this type of lesion
that if you consider, or as I did consider that this
baby's course was being directed by the profound
impairment of his left pumping chamber, that I would
not expect to see great improvement in this baby.

12

13

Q. And in your view of those two
days you did not, is that correct, Doctor?

14

A. Correct.

15

16

Q. I take it, Doctor, that the
next day you did participate in the surgical confer-
ence at which this child's condition and candidacy
for surgery was discussed.

17

A. Correct.

18

Q. Can you help us, Doctor, as

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to what the consensus of opinion was at that meeting?

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A. As I have already indicated
critically ill infants with severe impairment of the
left ventricles, with this coronary problem, just
don't do well at all. We reviewed with Dr. Trusler
I believe and Dr. Williams, our clinical concerns that
this baby had a coronary artery abnormality. We felt



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that perhaps the only thing one could try and do was
to revascularize the left pumping chamber, and to do
that the surgeon needed to say exactly what the
coronary anatomy was.

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So I believe it is the decision, as
it says, our work is pretty guarded at best and we
will do a catheter investigation to describe in
precise terms the coronary artery anatomy and then
to make a surgical decision based on those findings.

Q. And as a result of that

conference, Doctor, was the decision made to schedule
Kelly Monteith for surgery?

A. Yes.

Q. And that as I understand it
was scheduled for the 21st of August?

A. Yes.

Q. Was a cardiac catheterization
performed following the surgical conference on the
18th?

A. Correct.

Q. Did you participate in the
conduct of that catheter study?

A. No, I did not.

Q. Could you turn with me, Doctor,
to page 13 of the record, which is I take it



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is your reporting letter to the referring physician,
Dr. Verbeek, dated August 19th, that is the day after
the child's death.

5

A. Right.

6

Q. Was there, to the best of
your knowledge, Doctor, on the basis of the surgical
conference on the morning of the 18th and the
catheter study that was conducted later that day,
any reason to suspect that on the basis of the child's
condition at that time that she would not live long
enough to reach surgery on the 21st of August?

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A. I think - I have told my
parents for many years that I wish I had a crystal
ball. Again, I think the decision was made to try
and carry this sick little baby another couple of
days for surgery. Obviously if I had a crystal ball
which had been working we would have done something
earlier.

This baby was severely ill, had a

terrible outlook medically and surgically. Surgeons
are not pleased to have to try and operate on children
when they know that 99 per cent of the children will
probably die.

So my concern is that if she died I

was saddened that she died before making it to surgery,



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but with what we have already talked about, I think
it was understandable and perhaps predictable.

3

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Q. Doctor, perhaps I didn't put
my question clearly, and if not I apologize. At
the surgical conference on the morning of the 18th,
and based on the catheter study that was conducted
later that day, was there then any reason in your
mind, or to your knowledge in the minds of the surgeons
and the other staff cardiologists who had discussed
her case any reason to think that her condition would
sufficiently deteriorate that she would not reach
surgery on the 21st?

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A. I can't recall specific

discussion as to whether we should do it the 19th
or the 20th or the 21st. We realize that whenever
we did it it was going to carry an extremely high
risk. Certainly we felt that we should let a child
excrete the contrast material before taking the child
to surgery. Again to show the coronary artery
anatomy one has to inject in this baby's aorta the
hyperosmolar contrast which we know can worsen cardiac
failure. So I can certainly see a delay of a day or
so.

Q. You are referring, Doctor,

to the contrast material that is used during the



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catheter study?

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A. Correct.

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Q. And that in itself is an
intrusive technique which I gather some children in
a state of fluctuating condition might find difficult
to sustain?

5

A. Well, I can remember telling
Mr. and Mrs. Monteith, I think Mrs. Monteith, I
thought the baby could die during the catheter study.

6

Q. Doctor, we have heard evidence
that early in the morning of August 19th, approximately
3:40 a.m. a Code 25 was called and the baby in fact --

7

A. Let me back track. If I
remember also, Miss Cronk, this child sustained an
arterial injury and was on heparin. I may have
that confused with another child. It was my
recollection after the catheter study this child
did not have a good pulse in the leg and was placed
on heparin. Yes, that's true, I see a note here
August 18th.

18

Q. What page are you referring to,
Dr. Freedom?

21

A. I am referring to page 46.
When one is concerned about the viability of a leg,
that is when it is a known complication of the

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catheter procedure, especially in small infants,
that when one has to put the catheter through the
artery there are a substantial number of these infants
will develop an arterial thrombosis which needs
treatment with heparin. One is often reluctant to
take a baby to surgery on that ground alone, because
if after surgery the baby's cardiac output is marginal
one might not profuse the leg enough and one could get
a gangrene leg.

10

Q. And you are referring, Doctor,
to the progress notes on the 18th of August at the
top of page 46?

13

A. Correct.

14

Q. Where it refers to, I take
that to be a "catheter complication"?

16

A. Correct.

17

Q. No "palpable" pulse in the
right foot?

18

A. No palpable right pedal
pulses.

20

Q. Is that pulse in right foot,
is that what it means?

22

A. Correct.

23

Q. Can you help me with the
balance of that entry, Doctor: "Though..."

24

25



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A. "...though posterior tibial
could be detected with a doppler".

3

4

Q. So I take it then, Doctor,
that in your view as a result of that experience
post decatheterization of this child, that there
was another reason to be concerned about the child's
ability to proceed to surgery and her general condi-
tion at that time.

5

A. Correct.

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Q. Now, Doctor, if you would
turn with me again to page 13 your reporting letter
to Dr. Verbeek.

A. Is that on page 13?

Q. Page 13 of the record,

Doctor, the reporting letter dated August 19th,
1980.

A. Right.

Q. I take that to be your letter
reporting to the referring physician, both as to the
child's condition immediately before death, the
results of the discussion at the surgical conference
on August 18th.

A. Right.

Q. And the reporting of her
death on the morning of August the 19th, is that
correct?



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A. Yes.

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Q. Now, Doctor, as you have described in the second paragraph of your letter to Dr. Verbeek:

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"As I mentioned to you, she was discussed at our Surgical Conference on August 18th, and it was felt that she would be a candidate for some type of surgical procedure to redirect her coronary artery to her aorta. Certainly with a severe and global impairment of her left ventricular function, she was considered a high risk, and as you know by this time she died suddenly early in the morning of August 19th."

Doctor, are you familiar with the terminal events sustained by this child on the morning of the 19th?

A. Yes.

Q. You have had an opportunity to review them in the progress notes?

A. Correct.

Q. You will recall then, Doctor, if I might briefly summarize them, and I refer you to page 47 of the progress notes that at



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approximately 3:40 a.m. the child's apex became
irregular, the pupils dilated, she went into ventricular
fibrillation despite medications and resuscitative
efforts she reverted to ventricular fibrillation,
then went back to sinus bradycardia and after about
65 minutes of resuscitative efforts she was pronounced
dead. Is that a fair summary of the terminal events
that we see set out on pages 47 and 48 of the progress
notes, Doctor?

10

A. Correct.

11

Q. On the basis of those events,
Doctor, and on the basis of the severity of her
condition as you have described it following the
catheter study on the 18th, can you help me as to
why you described to Dr. Verbeek her death as having
been sustained early in the morning of August the
19th, suddenly.

17

18

A. Your concern is with the

word "sudden"?

19

20

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Q. I would like to know, Doctor,
what you regarded as the time limit of these
events when you felt when you were reporting to
Dr. Verbeek that she had taken a sudden downturn for
the worst. That seems to be suggestive I suggest to
you in the terminal events described in the progress
notes.



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A. Well, I think this makes a very good case for the fact that physicians are notoriously bad writers, and certainly I have expunged the word "sudden" from my vocabulary.

6

7

Q. I can understand why one might be motivated to do that, Doctor.

8

A. Yes, so can I, Miss Cronk. Again I think that the word "sudden" is used in the context that I would have hoped this child would have survived to make it to surgery. We had decided on surgery two or three days down the road and unfortunately Kelly Ann did not survive.

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So in that context I didn't think it carried anything in terms of a sinister connotation. It was a connotation of disappointment of concern for this family and of the reality of how terrible this disease is.

Q. Doctor, when you wrote your reporting letter to Dr. Verbeek.

A. Yes.

Q. You had in your mind I would assume the condition of the child as you had observed it on August the 18th. The results of the --- I am sorry is that correct?

A. Correct.



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2 Q. The results of the catheter study?

3 A. Correct.

4 Q. Which you had been informed again
5 on the 18th?

6 A. Correct.

7 Q. Had you personally observed or
8 examined the child through the evening of the 18th
9 and the early morning of the 19th prior to her arrest?

10 A. No. I don't believe I was on
11 call that evening.

12 Q. Right. When did you first learn
13 of her death and the manner of her arrest, Doctor?

14 A. I can't recall specifically but
15 I sort of told my fellows ever since I joined Sick
16 Children's back in '74 that even if I wasn't on call
17 I wanted to know if my patients died.

18 Q. Do you have any recollection -
19 I'm sorry, Doctor, I don't know what you're suggesting,
20 do you recall that you were contacted at the time of
21 her death?

22 A. Well, I am suggesting perhaps
23 they called me that morning early, you know, when the
24 baby died. I can't recollect specifically.

25 Q. Do you recall having participated
in the cardiology conference held, I take it it would
have been on the 19th later in the day after her



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(Cronk)

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2 death at 8:30 a.m. when the cardiology conferences
3 were normally held?

4 A. I can't recall specifically.

5 Q. Did you observe this child's
6 heart at gross autopsy, Dr. Freedom?

7 A. Yes, I did.

8 Q. Would that have been the same day?

9 A. Well, again, my ---

10 Q. To assist you, it is my under-
11 standing that the autopsy was conducted on the 19th of
August?

12 A. Correct. So, I must have
13 observed the heart during that day.

14 Q. On the basis of your observation
15 of her condition throughout her hospitalization,
16 Doctor, the description of her terminal events, your
17 observation of her heart at gross autopsy, were you
18 able to formulate an opinion as to the probable cause
of death of this child?

19 A. Well, as I said, Miss Cronk, in
20 my letter of August 19th, my last paragraph, that is
page 13, I say that:

21 "The necropsy findings confirmed
22 the clinical suspicion."

23 And the suspicion had been shown by the

24
25

Freedom, dr.ex.
(Cronk)

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2 angiography. No. 2, it showed an extremely severely
3 abnormal left pumping chamber and, so, I felt that
4 the disease was as bad as we had anticipated and
5 perhaps worse.

6 Q. And that her death was attributable
7 to that?

8 A. I think that goes without saying.
9 I think that, although I use the word "suddenly", I
10 think the following paragraph should put that into
11 perspective. Not only did I have a concern about this
12 baby during life but, Christ, look at this heart it
13 was so terribly damaged, both papillary muscles and
14 those of the support mechanisms had been infarcted,
15 there was calcification in the myocardium, that as bad
as we thought it was clinically it was worse on the
postmortem table.

16 Q. Doctor, we -- I'm sorry, were you
17 finished?

18 A. So, I felt that this certainly
19 explained this youngster's death.

20 Q. Did you subsequently receive a
21 copy of the preliminary and final autopsy reports of
22 this child, Doctor?

23 A. I can't recall specifically but
24 I presume that since it was my patient, since I did

25



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2 see the autopsy, they sent me one.

3 Q. Well, fairly, Doctor, I was just
4 going to point out that again on both the copy of the
5 preliminary and the final autopsy report contained
6 in the record, there is an indication that you were
7 copied on both reports?

8 A. Yes. Well, certainly, Miss Cronk,
9 having read these charts for these proceedings I have
10 seen that but back at the time I can't remember if I
11 saw them.

12 Q. Well, do you have any recollection
13 Doctor, of having been informed of any findings
14 following the final autopsy which either surprised you
15 or influenced you to reconsider in any way if you did
16 the opinion which you had previously formulated
17 concerning the cause of death of this child?

18 A. No.

19 Q. All right. As I understand it,
20 Doctor, Kelly Monteith had been receiving digoxin in
21 the Hospital?

22 A. Correct.

23 Q. And unlike some of the cases
24 that we discussed earlier this morning, a digoxin level
25 was obtained. My understanding is that that reading,
the sample was taken on August 18th and resulted in a
digoxin level of 2.5 nanograms?



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A. Correct.

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Q. That is the only level of which
I am aware in respect of Kelly Monteith immediately
prior to her death, Doctor. Are you aware of any
other?

6

A. No, that's the only one I am
aware of.

8

Q. Doctor, at the time of her death,
either at the cardiology conference that was held the
next morning or in any subsequent discussions that
might have been held after the post mortem results
were available, do you recall any discussions amongst
staff cardiologists or any member of the Pathology
Department or any member of the nursing staff as to
whether digoxin intoxication might have been a
contributing factor or a possible explanation for
this child's death?

17

A. Not only do I remember a
conversation, but seeing that the digoxin dosage was
appropriate, that there was a level recorded the day
before death, I would have seen no reason why that
should have come up in any context.

21

Q. Is that level of 2.5, Doctor, a
level which you would not find troublesome having
regard to what you described as the acceptable
therapeutic range for infant patients?

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(Cronk)

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A. I think it is at the upper

limits, certainly not at a range where I would be concerned.

5

Q. Thank you, Doctor.

6

Doctor, if we could turn now to the case of Paul Murphy.

7

8

9

His record, Mr. Commissioner, is, as you may recall, three volumes, Exhibit 80C. I think I need only refer you to the third volume, Dr. Freedom.

10

11

12

A. Let me just interrupt you, Ms.

Cronk. I have not reviewed Paul Murphy's chart at all for these proceedings. If you like, I will do so.

13

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Q. All right. Well, perhaps we can

return to it when you have had an opportunity to review it, Dr. Freedom. For the moment, may I simply ask you whether or not you were the staff cardiologist on call on the evening of his death? I should tell you fairly that it is my understanding that you were.

18

19

A. I would certainly bow to your

wisdom then, Ms. Cronk.

20

21

Q. All right. Well, perhaps we can

return to the death of Paul Murphy at a later stage.

22

Could we turn then, Doctor, to the death of Antonio Velasquez?

23

A. I do remember him.

24

MS. CRONK: Mr. Commissioner, that

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2 record is Exhibit 54.

3 Q. Again Doctor if I may to
4 summarize the events concerning this child at least
5 initially at the time of his admission, and please
6 correct me if my description is not in accordance with
7 your understanding. We have been told in evidence
8 that Antonio Velasquez was admitted to the hospital
9 at six months of age on August 19th, 1980, having
10 been referred to Dr. Rowe from a physician in the
11 West Indies. He subsequently died in the hospital on
12 August 24th, 1980 at approximately 4:25 a.m. Do I
13 have that correctly, Dr. Freedom?

14 A. Yes.

15 Q. As I understand it, Dr. Freedom,
16 although he was referred directly to Dr. Rowe, you did
17 participate directly in the care and the medical
18 management of his condition while he was hospitalized?

19 A. Correct.

20 Q. And do I have it correctly as
21 well, Doctor, that you were staff cardiologist on call
22 the night of his death?

23 A. Yes, you do, you do have that
24 correct.

25 Q. The nature of his condition,
Doctor, and the sequence of his terminal events have
been reviewed in some considerable detail in evidence



Freedom, dr.ex.
(Cronk)

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I 8 2 already and I don't propose to repeat the ground
3 already covered, but I would ask you to refer to page
4 15 of the record.

5 A. One-five, Ms. Cronk?

6 Q. One-five.

7 THE COMMISSIONER: Is this baby the
one where we have two page one-fives?

8 MS. CRONK: Mr. Commissioner, I am
9 referring to a letter from Dr. Rowe to Dr. Rao.

10 THE COMMISSIONER: That is the first
11 15 then?

12 MS. CRONK: The first 15 dated August
the 18th.

13 THE WITNESS: Indeed, I have page 15
14 which is a death certificate.

15 THE COMMISSIONER: Yes, I have that
16 too. Could you go back a bit Doctor, you will find
17 another page 15.

18 MS. CRONK: Q. You are looking for
19 a letter, Dr. Freedom.

20 A. To Mr. Velasquez?

21 Q. No, to Dr. Rao written by Dr.
Rowe.

22 A. Yes, that is my page 12.

23 Q. It is your page 12. Well, the
24 copying of the charts appears once again to have

25



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I 9 2 diffused at least I, Dr. Freedom.

3 A. It is dated August 28th?

4 Q. No, it is dated August 18th,
5 Doctor, there is another letter.

6 To assist you, Doctor, if you start
7 from the beginning of the record.

8 THE COMMISSIONER: I don't know
9 whether there is any consistency in the incompetence
10 but in mine if we go back to page 1 on the next,
11 going backwards, then we will come to 15.

12 THE WITNESS: If we go back to page 1
13 I go to 2, 3?

14 THE COMMISSIONER: No, no, backwards.

15 THE WITNESS: Ms. Cronk, why don't
16 you help me. Perfect.

17 MS. CRONK: Q. Doctor, as I under-
18 stand it, and perhaps we have gone through a great
19 deal of difficulty merely to establish what I
20 understand the evidence to indicate this child's
21 condition was at the time of the admission to the
22 hospital. Can you tell me, Doctor, do I have it
23 correctly that Antonio Velasquez was found to be
24 experiencing cyanosis at four or five months of age,
25 was found to have developed an enlarged liver, he
was observed to have begun to sweat a great deal and
it was further observed that he had slowed in his



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growth patterns?

2

A. That's correct.

3

Q. This is prior to the admission
to the Hospital for Sick Children?

4

A. That's correct.

5

Q. And in consequence of those
observations and those events, Doctor, digoxin was
apparently prescribed yet the cyanosis became more
frequent as did the sweating, which is recorded in
Dr. Rowe's letter to Dr. Rao, correct?

6

A. Correct.

7

Q. On admission to the Hospital for
Sick Children, as I understand it, Doctor, a cardiac
catheterization was performed and confirmed the
clinical diagnosis that had previously been reached at
the referring hospital of tetralogy of Fallot. Is
that correct?

8

A. Yes.

9

Q. Did you participate in the
conduct of that catheter study, Dr. Freedom?

10

A. No, I don't believe I did.

11

Q. And were you subsequently made
aware as to the results or findings that were
obtained on the catheter study?

12

A. Yes, we reviewed them the
subsequent day at our morning conference.

13



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I 11 2 Q. All right. Can you briefly
3 describe for us - I take it that the earlier
4 clinical diagnosis as I have suggested of tetralogy
5 of Fallot was confirmed by that procedure?

6 A. Correct.

7 Q. Right. And subsequently as I
8 understand it, and again correct me if I am wrong,
9 the child underwent surgery on the 21st of August for
10 a Blalock shunt and was sent post-operatively to the
ICU?

11 A. Correct.

12 Q. And he remained on the ICU for
13 some 24 hours and then was returned to the cardiology
ward?

14 A. That's correct.

15 Q. Can you help me, Doctor, as to
16 the status of his condition upon the return from the
17 ICU to the ward?

18 A. Well, the youngster on, I believe
19 it was the 22nd, 23rd, was certainly uncomfortable.
20 We had some concern as to whether or not there might
21 be a degree of congestive heart failure. He had
22 intermittent fever which suggested, I believe it was
23 to Dr. Wilkinson, the other Resident, that they should
24 do the appropriate type of investigations including
25 blood cultures and the like.



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Freedom, dr.ex.
(Cronk)

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Q. Well, Doctor, referring to the observations of Dr. Wilkinson, as I understand it he was a pediatric resident involved in the care of this child?

A. Yes, and a very good one.

Q. Can you help me, Doctor, by turning to page 4 of the record where we find a memorandum which appears to have been written by Dr. Wilkinson?

A. Yes.

Q. Concerning what he describes the events leading up to the death of Antonio Velasquez?

A. Correct.

Q. Have you previously seen this memorandum and had an opportunity to review it, Doctor?

A. Yes.

Q. All right. To summarize briefly the contents of the memorandum, Doctor, as I understand it, Dr. Wilkinson indicates that at about 1:30 p.m. on August 23rd Antonio was noted to have fever and tachycardia up to 200 per minute at one time?

A. Yes.

Q. He initially, the fever responded well, he records, to Tempra that rose again in the evening so that by 7:00 p.m. it was decided to



Freedom, dr.ex.
(Cronk)

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2 do another CBC and blood culture?

3 A. Correct.

4 Q. He continues:

5 "When last observed at 1:00 a.m. on
6 August 24th Antonio was sleeping,
7 breathing easily, he was afebrile ..."

8 no fever at that stage, Doctor?

9 A. Afebrile, right.

10 Q. "... and a heart rate of 130
11 to 140 per hour according to the
12 montior."

13 His condition appears to have improved from earlier
14 on the 23rd?

15 A. Right.

16 Q. Do you agree?

17 A. Correct.

18 Q. Right. He had received codeine,
19 as described by Dr. Wilkinson, 8 milligrams per dose
20 on three occasions during the day of August 23rd at
21 10:30 a.m., 6:30 and 9:30 p.m. and, as Dr. Wilkinson
22 describes it, it was felt that some of the tachycardia
23 was related to pain and this is why the third dose of
24 codeine was given earlier than originally ordered.

25 Dr. Wilkinson continues that:

26 "At 3:00 a.m. on August 24th he was
27 called to see the child ..."



Freedom, dr.ex.
(Cronk)

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I 13 2 I am now at page 2 of the memorandum:

3 "... because of bradycardia the
4 heart rate had dropped to below 90,
5 the child was somnolent and difficult
6 to arouse, pupils were constricted,
7 blood pressure in the left arm was
8 90, the temperature was 35.3."

9 Dr. Wilkinson then expresses the
10 view that the child had had too much codeine and he
11 consequently administered 2 milligrams of naloxone IV.

12 Stopping there for a moment, Doctor,
13 can you tell me whether in your view that dosage of
14 naloxone, given the condition of the child, was an
15 appropriate dosage?

16 A. No, I think it is too high, two
17 to two and a half times.

18 Q. And continuing with Dr.
19 Wilkinson's memorandum it records that the dose was
20 administered, that the result was, and as described
21 in the memo, as pupillary finding, we understand from
22 Dr. Rowe that that should read pupillary finding and
23 bradycardia, slowed respirations, felt the child --
24 it was on that basis that he felt that the child
25 might have experienced a codeine overdose.

26 In your experience, Dr. Freedom, are
27 those three symptoms as described by Dr. Wilkinson,



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2 that is, the pupillary finding, bradycardia, slowed
3 respirations indicative or suggestive of an overdose
4 of codeine?

5 A. Yes.

6 Q. They are certainly consistent
7 with that condition?

8 A. Certainly consistent.

9 Q. Yes. And then having
10 administered the first dose of naloxone, if you refer
11 to page 2 of the memorandum, Dr. Freedom, as we see,
12 recorded by Dr. Wilkinson, the result of the patient,
13 the heart rate increased, pupils dilated and began to
14 respond but the child didn't fully awaken. He
15 proceeded to administer a second dose of naloxone,
16 again, 2 milligrams?

17 A. That's right.

18 Q. So, I take it in your view that
19 that dosage was as well, two to two and a half times
20 what you would consider to be an appropriate dosage?

21 A. Correct.

22 Q. Okay. Almost immediately,
23 according to Dr. Wilkinson, the child had what he
24 called "extreme posturing". I take that to mean
25 seizure-like activity, the body went rigid?

A. Extensor posturing.

Q. All right. Can you help me as



Freedom, dr.ex.
(Cronk)

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2 to what that means?

3

4 A. Yes, I believe that the
youngster held his limbs in extension as opposed to
flexion.

5

6

Q. Is there any suggestion there of
rigidity?

7

8

A. I guess it would be hard to hold
your limbs extended and not be somewhat rigid.

9

10

11

Q. And the cardiac monitor at that
point showed no activity at all, went completely flat,
according to Dr. Wilkinson?

12

A. Okay, yes.

13

Q. Is that correct?

14

A. Yes.

15

16

Q. Resuscitation efforts were
commenced but were discontinued after an hour when no
successful results were obtained.

17

18

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Has Dr. Wilkinson, based on your
knowledge of this case, Dr. Freedom, accurately set
out the events of August 23rd and August 24th
concerning the demise of this child?

21

A. Yes.

22

23

24

Q. Based on your knowledge, prior
to the autopsy of this child, based on your knowledge
of his anatomical and clinical condition following
the catheter study, did it seem likely prior to

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2 autopsy that this child's death was attributable to
3 his heart ailments in your judgment?

4

5 this youngster should have done better and should
6 have survived surgery.

7

8 Q. All right. So, do I take it
9 correctly then, Doctor, that at the point that the
10 child died and prior to post mortem results being
11 available, you would not have considered the
condition of his heart to be of sufficient concern to
account for the manner of his death?

12

A. Correct.

13

14 Q. And subsequently we know, Doctor,
that an autopsy was in fact conducted. Were you
present at the gross autopsy of this child?

15

16 A. I certainly remember, Ms. Cronk,
17 seeing the autopsy findings. Again, I can't
18 recollect whether I was there when they opened the
19 youngster's chest or whether part of the autopsy had
been done and they showed me what they found up to
20 that point.

21

22 Q. Well, when you say that you saw
the autopsy findings, do you have any recollection of
23 having observed the child's heart?

24

25 A. Yes, I do remember seeing the
child's heart.



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Q. And did you subsequently become aware of the more detailed post mortem findings as recorded in the autopsy reports?

5

A. Yes.

6

7

Q. Would you turn with me, Doctor, to page 6 of the record, Doctor, if you would.

8

A. Page 6?

9

Q. Page 6. This is a memorandum prepared I take it by yourself addressed to Dr. Rowe dated August 26th?

10

A. Correct.

11

12

13

14

MS. CRONK: Mr. Commissioner, before moving into the contents of this memorandum, I will be a few minutes with it. Would it be an appropriate time to break at this stage?

15

16

THE COMMISSIONER: Yes, all right, we will rise until 2:30 then.

17

MS. CRONK: Thank you.

18

--- Luncheon recess

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2 ---On resuming at 2:30 p.m.

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THE COMMISSIONER: Yes, Miss Cronk?

4

MISS CRONK: Thank you, Mr. Commissioner.

5

Q. Dr. Freedom, before the

6

luncheon break we were discussing the death of
Antonio Velasquez, and more particularly I had drawn
your attention to the memorandum prepared by Dr.
Wilkinson as to the events leading up to his death.

9

Before we leave that memo, Doctor,
and I would refer you to page 5 of the record, which
is the second page of Dr. Wilkinson's memorandum, I
draw your attention to the symptoms or the condition
of the child that was being displayed immediately
prior to the administration of the first dose of
naloxone. And in that regard Dr. Wilkinson had
indicated that he was called to see Antonio because of,
first, bradycardia, less than 90 per minute, and that
when he arrived at the bedside he was somnolent and
difficult to arouse; peripheral pulses were easily
felt; blood pressure in the left arm was 90;
temperature was 35.3. Pupils were constricted.
Abdomen was soft. Liver edge was sharp and no more
than two centimetres below the right costal margin.

22

Stopping there for a moment, Dr.

23

Freedom, are those symptoms and physical manifestations

24

25



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2 which Dr. Wilkinson observed in the child's condition
3 consistent or indicative in your view of digoxin
4 intoxication?

5 A. No.

6 Q. Are any of the symptoms which
7 appear to have been displayed by the child prior to
8 the administration of the first dose of naloxone
9 suggestive in your view of potential digoxin effect?

10 A. One could be concerned that
11 bradycardia could be a manifestation of digoxin effect
12 or toxicity.

13 Q. And we know, Doctor, that this
14 child received digoxin and digoxin was administered
15 to him while he was in the hospital but to the best
16 of my knowledge there is no digoxin level reading
17 available with respect to Velasquez?

18 A. Correct. I believe it had
19 been started just 24 hours before.

20 Q. Right. And then if we move,
21 Doctor, to the symptoms manifested by Antonio Velasquez
22 immediately after the administration of the first dose of
23 naloxone, we see again from Dr. Wilkinson's memorandum
24 that within five minutes of administration of the dose
25 the heart rate had gone up to 140 a minute, the pupils
were dilated 2 to 3 millimetres and were responding



Freedom, dr.ex.
(Cronk)

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3 2 more briskly to light; his activity increased but
3 he didn't come fully awake.

4 Do I take that correctly, Dr. Freedom,
5 to be a partial response, if you will, to the
6 administration of the first dose of naloxone?

7 A. Yes, I would certainly
7 interpret it that way.

8 Q. It would not be I take it at
9 least in the view of Dr. Wilkinson as reflected by
10 this memorandum a complete response?

11 A. Correct.

12 Q. The child did not fully
12 awaken?

13 A. Correct.

14 Q. Is there anything in those
15 symptoms or in the progress notes or the materials
16 in the record of the child with which you were
17 familiar to suggest that the heart rate increased
18 sufficiently so as to be appropriately described as
19 tachycardia?

20 A. Well, again a heart rate of
21 140 per minute is somewhat above what I would consider
22 a normal heart rate for an infant of this age, and
23 sinus tachycardia I would think would be consistent
24 with a rate of 140 per minute.

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Q. And then moving to the second dose, the second administration of naloxone, Doctor, the symptoms if I could describe them as such, then demonstrated by Antonio Velasquez were quite simply the extensor posturing that you referred to earlier this morning, and an entire loss of any detectable electrical activity whatsoever; is that correct?

A. Correct.

THE COMMISSIONER: What is the time of that?

MS. CRONK: If we turn to - the description of the events starts at 3:00 a.m. on August 24th, Mr. Commissioner.

THE COMMISSIONER: What is the 3 o'clock ---

MS. CRONK: 3:00 a.m. is when Dr. Wilkinson is called to see Antonio Velasquez, and if we turn to the progress notes at page 48 of the record, Mr. Commissioner, the indication of timing is that a Code 25 was called immediately at 320 hours which suggests that the time elapsed between Dr. Wilkinson being called to observe the child, the administration of both doses of naloxone and the failure or the cessation of electrical activity was some 20 minutes.



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2 Q. Would you agree with that,

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Doctor?

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A. Yes.

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Q. I don't see any other time
indication for the progress notes of the 24th, Mr.
Commissioner.

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Dr. Freedom, with respect to the symptoms that were manifested by Antonio Velasquez following the administration of the second dose of naloxone, would you agree with me that having regard to the earlier administration of the dose of naloxone which produced what we have described as a partial response, it is difficult from the state of the record and the observations that are noted in the record to determine what the reaction would have been if the second dose had not been administered?

A. Correct. I would agree with that.

Q. Is it possible, Doctor, that if the second dose of naloxone had not been administered that the child's condition would have either improved or deteriorated or do you know what the likely progress would have been in the absence of the second administration?

A. I just can't respond to that.



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I think Dr. Wilkinson made a judgment
that this youngster had not - was still not awake and
he felt it appropriate to give a second dose.

5

6

Q. Right. Do you have any
personal experience with the administration of

7

naloxone for suspected codeine overdose, Doctor?

8

A. Yes, I do.

9

Q. Are the symptoms described by
Dr. Wilkinson to have resulted after the first
administration consistent in your view with what you
have observed to be normal reactions after the
administration of naloxone?

10

11

12

A. Yes.

13

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Q. Is it known to have the effect
of increasing the heart rate after administration?

16

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A. In the literature it has been
described both ways. Some children who seem severely
depressed who have bradycardia, their heart rates will
pick up as the children are moving around.

19

20

In other children, in other patients
there has been less comment about heart rate.

21

22

23

Most of the emphasis has been on
pupillary responses and on levels of consciousness.
And heart rate is not invariably mentioned in a lot
of the clinical reports on the use of naloxone.

24

25



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TORONTO, ONTARIO

Freedom, dr.ex.
(Cronk)

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7 Q. In your personal experience,
2
3 Doctor, are the symptoms described by Dr. Wilkinson
4 consistent with what you would have expected following
5 the administration of a dose?

6

A. Yes.

7

Q. Notwithstanding that the dose
8 was as you have described it approximately two and a
9 half times more than the recommended dose?

10

A. Correct.

11

THE COMMISSIONER: Doctor, has the
12 drug a purpose of its own other than to counteract
13 codeine?

14

THE WITNESS: It may, Mr. Commissioner,
15 but my familiarity is solely to counteract codeine.

16

MS. CRONK: Q. Dr. Freedom, could
17 you turn with me now, if you would, to page 6 of the
18 record which is the memorandum which I take to have
19 been written by yourself to Dr. Rowe under date of
20 August 26th which I referred to you immediately before
21 the luncheon break.

22

Do you have that?

23

A. Yes, I have.

24

Q. Doctor, in this memorandum you
25 record that you were notified at about 3:30 early
Sunday morning that Antonio Velasquez had sustained



1

8 2 a cardiac arrest, that resuscitation efforts had
 3 failed and that the child had died.

4 Do you recall who notified you of the
 5 death?

6 A. I think - I believe it was
 7 Dr. Wilkinson.

8 Q. Did you attend on the floor
 9 when Dr. Wilkinson contacted you?

10 A. I can't remember if I came in
 11 at that exact time or a few hours later.

12 Q. Several hours later after the
 13 death of the child did you have an opportunity to
 14 review the record and the progress notes that had been
 15 recorded with respect to his death?

16 A. Yes, I did.

17 Q. Did you do that, Doctor, before
 18 preparing this memorandum to Dr. Rowe?

19 A. Yes.

20 Q. And you continue in the next
 21 paragraph, Doctor, to indicate:

22 "On review Sunday morning of the events
 23 leading to this child's death -" and
 24 may I stop you there? What did the review entail?

25 A. Again it was a reviewing of the
 26 medications that the Velasquez child was taking at the



1

2 time, the exact sequence of events leading to the
3 use of narcan, the dosage of narcan, reviewing the
4 dosage of digoxin against the baby's weight, and
5 reviewing his chart in terms of his vital signs.

6 Q. Did you speak at that time as
7 well to Dr. Wilkinson as to the events that had
transpired?

8 A. Yes.

9 Q. And continuing, you indicate
10 that you were concerned about the temporal relationship
11 to the second dose of narcan. Can you help me, Dr.
12 Freedom, as to what you meant by that reference?

13 A. Yes. Again as you just recited,
14 the clinical events on that morning, it seemed that
15 this youngster's demise was very temporally related
16 to the second dose of narcan, and I was concerned,
therefore, was there a cause and effect.

17 Q. And by "temporally related"
18 I presume you mean approximate in time?

19 A. In time.

20 Q. You continued to describe
21 in your memorandum to Dr. Rowe, your opinion as to the
22 recommended dose of narcan and the actual dosages that
had been administered to the child. And then in the
23 next paragraph you state:

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"On my examination of the facts, my own personal knowledge was that narcan did not suppress the cardiovascular system or lead to irreversible hypotension."

Now stopping there for a moment, was that opinion as expressed in your memorandum to Dr. Rowe based on your own clinical observation and experience?

A. Yes.

Q. And I take it in your clinical experience as at that date you had neither observed in a patient in whose care you had participated nor were you aware of any reported case in the relevant literature which would support the view or theory that naloxone can have an effect on the cardiovascular system leading to irreversible hypotension?

A. No, I am not sure that is correct. I had remembered saying to Dr. Wilkinson - I couldn't place my fingers on it but I was aware of a report in the literature that I thought narcan could cause hypotension, but it wasn't something that I was used to seeing or perceiving, and I remember going to my own file of reprints to see if I had something immediately available on narcan and I didn't.

Q. Were you aware of that article,



1

11 2 Doctor, at the time you prepared this memorandum?

3

4 A. Again, Miss Cronk, I was aware
5 there might have been something that jogged my memory,
6 but not of a specific article.

7

8 Q. And I take it as part of the
9 review you conducted that morning you spoke as well
10 with Dr. Conn?

11

12 A. Correct.

13

14 Q. And he was as you have
15 described head of the Intensive Care Unit at the time?

16

17 A. Correct.

18

19 Q. And you spoke as well with
20 Dr. MacLeod, head of Pathology?

21

22 A. Head of Pharmacology.

23

24 Q. Head of Pharmacology?

25

26 A. Correct.

27

28 Q. Do you recall when you spoke
29 to Dr. Conn?

30

31 A. No. Again I remember speaking
32 to him obviously after the events of the early evening -
33 excuse me, early morning. Dr. Conn indicated to me
34 that you should be able to continue to push in narcan
35 until one had a sustained effect on the level of
36 consciousness.

37

38 Q. And by that do I correctly take

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it that you mean the patient would be fully awake?

3

A. Or at least more responsive.

4

Q. Than had been described for

5

Antonio Velasquez?

6

A. Correct.

7

Q. And similarly you have

8

indicated you spoke to Dr. MacLeod about the matter.

9

Do you recall when you did that?

10

A. No. But again I had the same type of input.

11

Q. You recorded in your memorandum to Dr. Rowe that Dr. MacLeod stated that narcan even in very toxic doses is not known to have adverse cardiovascular effect.

14

Do you recall that being the opinion expressed by Dr. MacLeod at that time?

16

A. Correct. And I do remember - I can't remember, Miss Cronk, whether it was Dr. Conn or Dr. MacLeod asking specifically about an idiosyncratic effect. That is an effect of the medicine that is not dose related. It is like giving penicillin twice to someone and the third time having an anaphylactic reaction, a terribly severe reaction.

22

Q. Sorry, Dr. MacLeod or Dr. Conn raised that?

24

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A. I can't remember who I addressed that to. One of those two.

4

5

Q. What was your view at the time as to the likelihood of that having occurred?

6

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A. Again I sort of have a perception that the comment was any one of us could have an idiosyncratic reaction. Again they placed it fairly low down in their list.

9

Q. In terms of likelihood?

10

A. In terms of likelihood.

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Q. Right. Did either Dr. Conn or Dr. MacLeod indicate to you during your discussions with them that they had had experience or were aware of previous cases where naloxone was known to have or to cause any idiosyncratic reaction in a patient to whom it had been administered?

16

A. I can't recall specifically.

17

18

Q. Had you at the time of those discussions any experience in that regard?

19

20

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22

23

A. Again the only thing I remembered was I had seen some report. It was either in terms of my practice years ago or in terms of literature, that there had been an article on that. I didn't have it in my own file and I didn't recall it at the time when I dictated this memo.

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Q. And I gather from the balance
of the memo to Dr. Rowe, Dr. Freedom, that you
subsequently became aware of postmortem results that
were obtained on this child?

A. Yes.

Q. Did you personally attend the
gross autopsy?

A. Yes.

Q. Did you observe the heart?

A. Yes.

Q. And you set out those findings
I gather in the penultimate paragraph at page 6 of
your memorandum. You indicate:

"Specifically at the time of the gross
examination there was nothing found
that could explain this youngster's
death."

A. Right.

THE COMMISSIONER: What page?

MS. CRONK: We are still on page 6.

THE COMMISSIONER: The same memorandum?

MS. CRONK: The same memorandum, sir,
the last paragraph on the page.

THE COMMISSIONER: Yes.

MS. CRONK: Beginning with the words



15

1 "A post mortem examination was performed and results
2 are pending."

3

4 THE COMMISSIONER: Yes.

5 MS. CRONK: Q. So I take it, Dr.

6 Freedom, stopping there for a moment, that although
7 you had attended the gross autopsy and observed the
8 heart, the full post mortem results were not available
9 as at the time of the preparation of this memo?

10 A. Right.

11 Q. And would I be correct in
12 taking it as well that based on the observations you
13 made at the time of the gross autopsy and the
14 observations you made of the heart itself, there was
15 not in your view a likely explanation for the cause
16 of death based on the anatomical conditions you had
17 observed?

18 A. I felt that we or I had underestimated
19 the severity of the congestive heart failure. This
20 youngster did have fluid in the chest cavity, in the
21 abdominal cavity at the time of autopsy, so I still
22 felt that the structural heart disease, that would
23 be difficult to explain the child's death directly
24 related to the heart disease that we found.

25 Q. And indeed, Doctor, you note
26 that the shunt at gross autopsy appeared to be working



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2 and functioning properly?

3 A. Right.

4 Q. And similarly you indicated there
5 was no evidence of a septic pulmonary thrombosis?

16

A. Correct.

6 Q. Pre and post mortem cultures
7 you indicate were pending as at the date of your
8 memorandum and you understood that a post mortem blood
9 level for narcan was also obtained.

10 Doctor, fairly I should tell you that
11 on my review of the record I have been unable to
12 discover the result of post mortem narcan level.

13 To your knowledge was a level in fact
14 obtained?

15 A. Well, I can't remember the
16 pathologist who did the autopsy but I certainly
17 remember my discussion with Dr. Gartha, and he suggested
18 that we get a post mortem narcan level and that had
19 been suggested.

20 I do, in the back of my mind, remember
21 someone reporting the narcan level as normal. I would
22 have to go through the chart or go through the
23 pharmacology reports.

24 Q. Doctor, when you refer to Dr.
25 Gartha, I presume you are referring to the Coroner?



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A. Yes.

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Q. Who was contacted in respect
to the case?

4

A. Yes.

5

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Q. Perhaps you could assist me
over the night, Dr. Freedom, and let me know in the
morning if you have been able to discover in the
record or any other records available to you a report
of post mortem narcan level in this child?

10

A. All right.

11

Q. If you would be so kind.

12

13

MISS FORESTER: If I can be of
assistance to my friend, there is in the report
a post mortem examination on page 5 of the record.

14

15

THE COMMISSIONER: There are two page
fives.

16

17

MISS FORESTER: It is not many pages
after the page 6 we were looking at. It indicates
narcan was not detected by toxicology.

18

19

MS. CRONK: Thank you.

20

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Q. Doctor, is that the
reference you recall seeing with respect to the
narcan level?

22

23

A. Yes.

24

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Q. And I take that to mean that



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on the basis that reference is contained in the report of the post mortem examination conducted pursuant to the Coroner's Act on Antonio Velasquez. Is that the only reference with which you were familiar with respect to the post mortem narcan level on this child?

A. Yes.

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THE COMMISSIONER: Doctor, is there such a thing, and I am sure there is as an overdose of narcan as there is an overdose of any kind of drug, but what would the effect be?

THE WITNESS: In my reading, Mr. Commissioner, done after the fact, an overdose of narcan can produce the same effects as the drug for which it is being given. It could cause somnolence ---

THE COMMISSIONER: The same thing as codein

THE WITNESS: Correct.

MS. CRONK: Mr. Commissioner, my friend Mr. Hunt has provided me with a report from the Centre for Forensic Sciences, dated January 23, 1981, with respect to Antonio Velasquez which indicates that a sample of blood was received and tested at the Centre and that no naloxone or narcan could be detected.

With Mr. Hunt's concurrence, I don't



1

2 believe this has been marked as a previous exhibit
3 and perhaps it could be marked at this stage.

19

4 THE COMMISSIONER: What was the time
5 of the test because you notice on the page - one of
6 the many pages 5 of Exhibit 54 it says that narcan
7 or naloxone metabolized very rapidly and possible
death due to overdose cannot be ruled out.

8

9 MS. CRONK: That is dated January
10 20th, 1981, Mr. Commissioner, and the report from
11 the Centre for Forensic Sciences is dated January
12 23, 1981, three days later.

13

14 THE COMMISSIONER: This child died on
15 the 24th of August.

16

MS. CRONK: In 1980.

17

18 THE COMMISSIONER: In 1980. I have
19 no idea what metabolized very rapidly would mean
20 but I would think it would mean something less than
21 five months.

22

23 MS. CRONK: One would have thought so,
24 Mr. Commissioner.

25

26 May this then be marked, sir, as the
27 next exhibit, and I will undertake to provide copies
28 to my friends.

29

30 THE COMMISSIONER: All right. Exhibit
31 168.

32

33



Freedom, dr.ex.
(Cronk)

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2 ---EXHIBIT NO. 168: Copy of report from Centre for
3 Forensic Sciences dated January
23, 1981.

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6 MS. CRONK: Q. Dr. Freedom, did you
at some subsequent point become aware of the results

7

8 of testing done at the Centre for Forensic Sciences
9 for post mortem narcan levels?

10

A. Yes, I was.

11

Q. You were aware of that?

12

A. Yes.

13

Q. Do you recall when you were
made aware of that?

14

A. No, I don't.

15

Q. Prior to the release of the
post mortem report that we have seen at page 5 of the
record in January of 1981, had you been made aware
prior to that time by any member of the Pathology
Department or any member of the Coroner's offices
as to the results concerning the post mortem narcan
test?

16

A. I can't remember specifically.
I just remember that in my discussion with Dr. Gartha
that it was obtained and at some point later in time
I was told that it was low and normal.

17

Q. Doctor, as the Commissioner
has pointed out the reference on page 5 of the

18

19

20



1
2 post mortem examination results indicate that narcan
3 was in fact not detected at postmortem. Is that
4 correct?

5 A. Correct.

6 Q. And then the further indication
7 is that the substance metabolized very rapidly
8 and possible death due to overdose cannot be ruled
9 out.

10 Are you in a position to help us,
11 Doctor, and I recognize the area of your expertise,
12 and if you are in a position to help us can you give
13 us any assistance as to what meaning we should
14 attribute to the suggestion that narcan metabolizes
15 very rapidly in the body?

16 A. No, I really can't.

17 Q. Now you have indicated that
18 at some time, Dr. Freedom, in the preparation of
19 your memorandum to Dr. Rowe you had a recollection or
20 some indication of an article in the literature which
21 dealt with the issue of the possibility of an effect
22 by narcan on the cardiovascular system of the body,
23 and I take it at some point subsequent to the
24 preparation of this memorandum you did have an
25 opportunity to search for and to locate that article?

A. Correct. As a matter of fact



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before I really started my search which was the next week one of the members of the Department of Anaesthesia handed me a sheaf of papers on narcan and the cardiovascular system.

Q. And was the article to which you referred contained in those papers?

A. I can't remember Miss Cronk, which article I had in the back of my mind but certainly there was an article there that I was interested in.

MS. CRONK: Mr. Registrar, could the witness be shown 166, please?

THE WITNESS: I believe that is the paper, "Ventricular Irritability".

MS. CRONK: Q. Did you have a copy of that, Dr. Freedom?

A. Yes.

MS. CRONK: Exhibit 166, Mr. Commissioner, you will recall is an article entitled "Ventricular Irritability Associated with the use of Naloxone Hydrochloride".

Q. Is this the article that was subsequently drawn to your attention, Dr. Freedom?

A. Yes, this and several others.

Q. All right. Dealing first with



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this article if we may, was this article part of
the materials that were provided to you as you said
approximately a week after Antonio Velasquez' death?

4

A. I can't remember the exact time
framework, but it was within a week or two. And, yes,
it was provided to me through the Department of
Anaesthesia.

8

Q. Did the contents of this
article and the case description contained in the
article of the two separate female adult patients
cause you in any way to alter the opinions that you
had expressed in your memorandum to Dr. Rowe of
August 26th?

13

A. Yes, it did. I had been
concerned that evening even having spoken with
Drs. MacLeod and Conn of an idiosyncratic reaction.
When I read this paper, again these adult patients
died following narcan administration, and I felt that
this would be supportive of an idiosyncratic type of
death.

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Q. Doctor, based on my review of the article and the two cases that are described there - the first was of a sixty-six year old adult woman and the second of a thirty-six year old woman, both, I take it, who had undergone cardiac pulmonary bypasses?

A. Right.

Q. And in both instances, doctor, based on my reading of the article, following the administration to each of naloxone, both patients were reported to have experienced immediate ventricular fibrillation; is that correct?

A. Correct.

Q. And electrical defibrillation in respect of each was then carried out as a result?

A. Correct.

Q. Would you agree with me, doctor, that based on the symptoms described by Dr. Wilkinson, as the terminal events sustained by Antonio Velasquez, ventricular fibrillation was not a symptom which was recorded in his case?

A. I would look at it somewhat differently. I would say that these adult patients sustained a very severe cardiovascular reaction to narcan. Children and infants are less likely to fibrillate but could still sustain a severe cardio-



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2 vascular reaction. So, I would look at it a little
3 bit differently.

4

Q. Yes. I understand that,
5 doctor.

6

I believe my question to you was:
7 Based on the symptoms recorded by Dr. Wilkinson to
8 have been experienced by Antonio Velasquez at the
9 time of his death, and more specifically at the time
10 of the administration of both doses of naloxone,
11 ventricular fibrillation was not a symptom manifested;
is that correct?

12

A. Yes.

13

THE COMMISSIONER: Ms. Cronk, this
14 is a cry from the heart and it may not find any
response.

15

Doctor, this is not really your
16 field of expertise?

17

THE WITNESS: Right.

18

THE COMMISSIONER: You being a
19 consultant.

20

THE WITNESS: No. You are being
helpful.

21

THE COMMISSIONER: And it seems to
22 me that these questions, I know there is a purpose
23 perhaps in putting to him what his views are, what

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2 perhaps should have been done. Surely, that kind of
3 question would be better directed to a pharmacologist,
4 would it not, as to what the effect is? The only
5 reason I say that is it seems to me it is difficult
6 to ask you, who have spent all your time in cardiology,
7 to give us an answer as to when this narcan is going
to react to kill off the patient.

8 MS. CRONK: Well, Mr. Commissioner,
9 I certainly do not disagree. However, in this parti-
10 cular issue, Dr. Freedom, in his memorandum to Dr.
11 Rowe, expressed an opinion based on his experience and
12 his discussions with other members of the Hospital as
13 to the known effect of the drug naloxone.

14 THE COMMISSIONER: I don't blame
15 him for expressing that opinion. With respect, I am
16 not going to pay so much attention to that opinion of
17 his as I would -- my task is to find out how these
children died.

18 MS. CRONK: No, I understand fully,
19 Mr. Commissioner.

20 THE COMMISSIONER: All the doctor
21 can say is there was a certain amount of this drug
22 given to the children, and it would seem to me that
23 the result of that -- Now, I never know where we are
leading. It may well be that you have some other

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2 purpose with that line of questioning. If it is
3 to try to persuade me, through the doctor's answers,
4 that this drug could or could not have caused the
5 death, I would be happier to have it from a
6 pharmacologist, that's all. I am really attacking
7 you with a mind to attacking any other counsel that
may come after you who will want to --

8

9 MS. CRONK: I take great confidence
that I am in good company in that regard, Mr.
10 Commissioner.

11

12 THE COMMISSIONER: I suspect you
will be, in that respect, but I perhaps am not one of
13 them.

14

15 MS. CRONK: Mr. Commissioner, with
your indulgence then in respect of this issue.

16

17 Q. Doctor, you have told us
what your view was at the time of preparing this
18 reporting memorandum to Dr. Rowe. You have told us
as well as to your subsequent discovery of the article
19 that we have just examined, and it suggested to you
that there was a known incident of a cardiovascular
20 adverse effect caused by naloxone.

21

22 Can you help me, doctor, after you
had reviewed that article and fully reviewed the
23 circumstances of this child's death, did you formulate

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BB5 2 an opinion as to the likely or probable cause of his
3 death?

4 A. Yes. Although the Professor
5 of Anesthesia, Dr. Conn, and Dr. MacLeod felt that
6 this was an unusual response, I felt that this
7 article and literature had given the idiosyncratic
8 concern, that I had some support. It seemed temporarily
9 related, from Dr. Wilkinson, that this electro-
10 mechanical dissociation followed almost immediately
11 the second dose of narcan, and that is what I con-
12 cluded.

13 Q. And was anything that was
14 relayed to you, which came to your attention as a
15 result of the post mortem that was conducted, was
16 anything significant, in your view, in that regard
17 that led to an alteration or a change in thinking on
18 your part as to the likely cause of death of this
19 child?

20 A. No. I had concerns right
21 from the moment I heard this youngster had died, Miss
22 Cronk, that it should be reported to the Coroner's
23 office. I felt it was a temporal relationship
24 to a drug, and that is what I did.

25 Q. And indeed, doctor, as I
understood your reference to Dr. Gartha earlier, you



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were sufficiently concerned by this child's death
that you did, in fact, report it to the Coroner; is
that correct?

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A. Yes.

6

Q. And you did so personally?

7

A. Yes.

8

Q. Do you recall when you first
contacted the Coroner's office in that regard?

9

A. All I can remember is it was
sometime after this youngster, the cardiac arrest and
death, and it was sometime early Sunday morning.

10

Q. Was the case accepted as
a Coroner's case at that point?

11

A. No, it wasn't.

12

Q. Can you tell me, if you recall,
Dr. Freedom, upon what basis it was not accepted as
a Coroner's case at that time, or do you know?

13

A. I can't recollect my exact
discussion with Dr. Gartha. I remember expressing
concerns about narcan. This youngster, Velasquez,
was also a relative of one of our residents in the
Hospital, and I felt, for that reason as well, I
wanted the case reported to the Coroner and to be
taken into the Coroner's jurisdiction.

14

Q. As I understand your evidence,

15

16



BB7 1 do I correctly have it, then, that the reason that
2 you reported this case to the Coroner, the reasons
3 were twofold: First, because of your concern as to
4 the temporal relationship of the death in light of
5 the second dose of naloxone administered and, secondly,
6 because of the relationship of one of your residents
7 in the Hospital?

8 A. I think the first was
9 really the prime reason why I reported it. I certainly
10 felt I had a responsibility as a physician.

11 Secondly, I felt it would be
12 important for the resident on the House Staff to know,
13 as I said, it was reported and that he could have a
14 full autopsy review through the Coroner's office.

15 Q. In your discussions with
16 Dr. Gartha on Sunday following Antonio Velasquez'
17 death, do you recall today, Dr. Freedom, whether there
18 was any discussion as to the effect, or known effect,
19 of naloxone on the cardiovascular system?

20 A. Yes. I think I had mentioned
21 to him that I had spoken with Dr. Conn and Dr.
22 MacLeod. I spoke to Dr. Gartha a couple of times,
23 and I can't remember at which time I addressed these
24 issues. They felt it was unlikely a direct cause and
25 effect from their clinical experience.



1

2 Q. I gather the case was
3 ultimately accepted as a Coroner's case?

4 A. Yes.

5 Q. Can you tell me how that
6 came about, doctor?

7 A. If I recollect properly,
8 we again reviewed the case on Monday morning at the
9 morning work conference. I had mentioned to my
10 colleagues that I had called Dr. Gartha, that it was
11 my understanding that the case had not been accepted,
12 and the overall view of my colleagues was, "Call him
again."

13 Q. And you did so?

14 A. Right.

15 Q. And at that time, was the
16 case accepted as a Coroner's case?

17 A. Yes.

18 Q. You referred to the morning
conference. Would that be the cardiology conference?

19 A. Yes.

20 Q. Which followed after the
21 death of the child?

22 A. Right.

23 Q. Dr. Freedom, Dr. Rowe has
24 testified that the conclusion or consensus reached at

25



1

2 the cardiology conference held after Antonio
3 Velasquez' death as to the likely cause of his death
4 was that he had suffered an idiosyncratic reaction
5 to naloxone following its administration in a situa-
6 tion where his post operative course had been
7 complicated both by earlier heart failure and probably
infection.

8

9 Did you share that view at that
conference, doctor?

10

A. Yes.

11

Q. The possibility of infection,
12 as I understand it, was not, however, confirmed as
13 a result of the post mortem examination and findings;
is that correct?

14

A. Certainly, bacterial in-
15 fection was not confirmed, no.

16

Q. Was there a suggestion of
infection, non-bacterial oriented?

18

A. In the sense that this child
had been febrile, and I think one would be concerned
that, if you can't culture a bacteria, perhaps there
is an intercurrent viral infection.

21

Q. Was there any suggestion or
indication in the progress notes of the child or
observation made during the course of his treatment that

24

25



Freedom
dr.ex. (Cronk)

1

BB10 2 in your view, supported the suggestion that there might
3 be a viral infection that had not been detected at
4 post mortem?

5

A. Well, just that he was
febrile.

6

Q. Anything else?

7

A. I can't remember specifically,
8 but I think it was just that he had not been doing
9 well and complained of lots of pain, had ongoing
10 fever.

11

Q. You have always told us,
12 doctor, as I understood your previous answer, that,
13 in your judgment and opinion at the time, the cardiac
14 condition of the patient itself could not explain his
death.

15

A. Yes. I would agree with that.

16

Q. Would you agree with me,
17 doctor, on the basis of what you have told us of
18 naloxone and the experience of both yourself and the
19 physicians in the Hospital with whom you would dis-
20 cuss the matter, that it was most unusual to have a
21 case where it was felt a patient suffered an adverse
22 and, indeed, fatal reaction, idiosyncratic though it
might be, to this drug?

23

A. Certainly, the experience of

24

25



Freedom
dr.ex. (Cronk)

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BB11 2 Drs. Conn and MacLeod was such that it was a low
3 priority. Again, I felt this concern of idiosyncratic
4 reaction was sustained and supported by the literature
5 which I was given that week.

6 Q. It was certainly, however,
7 unusual in your experience to observe or witness that
kind of situation?

8 A. Correct.

9 Q. But based on the concerns
10 and the discussions that you had, it was a possibility
11 that could not be excluded?

12 A. Correct.

13 Q. Do you recall, Dr. Freedom,
14 any discussion at the cardiology conference following
15 Antonio Velasquez' death as to whether digoxin intox-
16 ication had been a contributing factor or had to be
17 considered as a potential contributing factor to his
18 death, quite apart from the issue of the effect of the
19 naloxone demonstration?

20 A. I remember, Ms. Cronk, stating
21 that, before I dictated my memo to Dr. Rao, I had
22 reviewed the medication that this youngster was on,
23 and the only concern that I had was the temporal re-
24 lationship to a dose of narcan that was somewhat above
25 what we would normally have recommended.



BB12

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Q. Apart from the concerns that you personally had at the time of preparing that memorandum, which I take it was prepared prior to the cardiology conference meeting, do you recall any discussion at the meeting by any of the other staff cardiologists with respect to the issue of potential digoxin intoxication?

8

9

A. No. I don't remember any such conversations.

10

11

12

Q. Do you remember any such discussion, if at all, following the post mortem results, when they ultimately became available?

13

14

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17

18

A. No.

Q. Thank you, doctor.

Doctor, by the time of Antonio

Velasquez' death on August 24th, there had been, according to the information provided to us, eleven deaths on the ward since the beginning of July, if you include Laura Woodcock, who died on June 30, 1980.

19

A. Right.

20

21

Q. And I take it, for at least part of that time, you had been Ward Chief on the ward, you told us, in mid-August?

22

A. Right.

23

24

Q. You had, on other occasions, been the Staff Cardiologist on call at night?

25



1

BB13 2 A. Correct.

3

4 Q. And you had, as well, per-
5 formed your normal duties during the day, save for
6 the period when you think you may have been on
7 vacation during that summer?

8

A. Right.

9

10 Q. Can I correctly take it
11 then, doctor, that, by the time of the death of
12 Antonio Velasquez, to the end of August, you were
13 aware of what appeared to be an unusually high or
14 increased number of deaths on the wards than had
15 previously been experienced?

16

A. Correct.

17

18 Q. Can you tell me, doctor,
19 when you first had the impression that an increasing
20 number of deaths had or were occurring on the wards?

21

A. I think during the latter
22 part of the summer.

23

24 Q. Did any staff cardiologist
25 or any of your colleagues on the wards draw this
matter to your attention or raise it with you in
discussion at that point in time?

26

27 A. I am not sure, Ms. Cronk, on
28 a one-to-one basis. Again, we had numerous discussions
29 at our morning conferences about the children that we

30

31



Freedom
dr.ex. (Cronk)

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BB14 2 were seeing that had died. So, there was ongoing
3 discussion between my colleagues and me as to the
4 babies that were dying.

5

Q. I take it, Dr. Freedom,
6 that the sheer number of deaths themselves would have
7 been of concern, both to yourself and to your colleagues?

8

A. Not entirely. I think we
9 were concerned by the numbers but, as we reviewed the
10 types of patients, or at least the anatomy, that we
11 were given some support that these babies had terribly
severe heart disease.

12

Q. When you talk of reviewing
13 the anatomy and the clinical condition of these
14 children, Dr. Freedom, I am talking now again of the
15 time period at the end of August 1980, are you talking
16 about the daily reviews of the cardiology conferences
17 which would have been conducted on a day-to-day basis
after the death of a particular child?

18

A. Yes.

19

Q. There was no meeting, as I
20 understand it, during the summer months, July and
21 August, for the purpose of a general review of the
deaths which had occurred?

22

A. Correct.

23

Q. Do you recall, Dr. Freedom,

24

25



1

BB15 2 any member of the nursing staff raising with you,
3 or drawing your attention to, the increased number of
4 deaths that appeared to have been occurring in July
5 and August on these wards?

6

A. I don't recall any nurse
7 coming directly to me. I am aware that, in response
8 to nursing concerns, Drs. Rowe, Richard Rowe, and
9 Jedeiken organized an afternoon conference with the
nurses in September.

10

Q. And that we have heard,
11 Dr. Freedom, and I will refer to it in a moment, was
12 the mortality meeting that was held on September 5th?

13

A. Correct.

14

Q. Prior to that meeting, doctor,
15 had any member of the nursing staff approached you
16 personally to discuss or raise with you the issue of
these increasing deaths?

17

A. I don't recollect whether it
18 was before that or after that, but I do remember having
19 a conversation with Miss Carol - her married name
20 is Brown - but her name in those days was Carol
21 Putherbrough. Again, I can't remember whether it was
22 after the September 5th meeting or before.

23

Q. And what was raised with you
at that time, or what did you raise with her at that

24

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BB16 2 time, concerning these deaths?

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A. I think - again, my recollection is somewhat foggy. I have had so much concern over the last two and-a-half years that it is difficult to put it into a time perspective. I think the gist of it, though, was that the nurses were concerned by the number of babies dying on the floor.

Q. Was that a concern expressed by her to you?

A. I can't remember if it was expressed directly to me or whether it came out during this meeting we had with some of the nurses in early September.

Q. Do I have it correctly, doctor, you don't recall whether that discussion took place at or prior to the meeting?

A. Or subsequent.

Q. On the basis of your own observation as to these deaths, doctor, and the number of deaths involved during the summer months and on the basis of your discussion with the member of the nursing staff that you have just described, to what did you attribute, or were you able to attribute, if anything, the increasing number of deaths that were occurring?



Freedom
dr.ex. (Cronk)

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BB17

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A. I think the underlying

matrix of the heart abnormality, the terrible
severity of the malformations that we were seeing.

5

6

7

8

Q. Were the babies that were

being admitted to the cardiology wards in the summer
of 1980, doctor, in your judgment, presenting with
cardiac abnormalities of the kind or combination
which you had not seen before?

9

10

11

12

A. I wouldn't use the words,

Ms. Cronk, that "we had not seen before". We just
had an overall feeling that we were seeing more of
them; they were sicker and younger and they had a
bad disease.

13

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For instance, there were some babies

with a hypoplastic left heart syndrome that normally
was sent back from 7G to the referring hospital, but,
for administrative reasons or family concerns, ended
up on the heart floor and died; like Perreault and
those. So, as we looked over those deaths, the
hypoplastic left heart, Kelly Monteith, Dion
Shrum, David Taylor, we felt that there was certainly
ample, sadly enough, adequate reasons for these
babies dying.

22

23

24

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Q. Doctor, in the normal

circumstance, I would take it - and please tell me if



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BB18 2 you disagree with this feeling - the sick children
3 that are admitted for cardiac consultation or that
4 are referred to the Hospital for Sick Children for
5 cardiac consultation, if they are gravely ill, in the
6 first instance, would be considered as ICU candidates;
7 is that correct?

7

A. I would think that is a fair
8 statement, and would certainly think, where is the
9 best logistical place for any given patient.

10

Q. Did you, in your experience
11 during the summer of 1980, doctor, observe that there
12 were more admissions to the ICU of critically ill
13 children than there had been in the months prior to
14 the beginning of the summer?

14

A. Again, it is difficult for
15 me to remember my perception of the ICU in the summer
16 of 1980 versus now. I had the feeling, and it is only
17 that, that there were more infants, that the transport
18 helicopter was now in place at the Hospital for Sick
19 Children. If I remember as well - and, again, you
20 may be able to correct me - they were doing some
21 construction down near the ICU to try and enlarge some
22 of the area for all patients. So, I felt that the ICU
23 did have a bed constraint plus more demand.

23

24

25

Q. Doctor, other than the case of



1

BB19 2 Dionne Schrum, which we earlier discussed, did you,
3 during the summer of 1980, ever have a case when you
4 wished a patient, because of the severity of his or
5 her condition, to be admitted to the ICU only to find
6 that that was not possible due to bed shortage or
construction that was taking place?

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A. I just can't recollect that.

3

I know we talked earlier this morning about Kelly Monteith, that she went down for one day, or over-night, but other than Shrum, that sticks out clearly in my mind, I can't recollect those.

6

Q. And, Doctor, dealing again with the incident of the numbers of death occurring during these summer months, did you at the end of August when you observed that there were an increased number of deaths, come to any observation or did you formulate the impression that there was anything unusual about the time at which these children were dying?

12

A. No.

13

Q. Did you have any impression at all as at the end of August, 1980, as best you can recall today, Dr. Freedom, with respect to the fact that a number of these children were dying between the hours of 1:00 a.m. and 5:00 a.m. on the cardiology wards?

19

A. Right. So, I think to backtrack, yes, I think they had come up in discussions and, again, with the nurses, that these children were dying at night.

22

Q. Well I'm sorry, Doctor, I am now left in some confusion and perhaps I haven't understood your answer. Did you at the end of August, 1980, have

25



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any impression, or did you formulate an impression
2
that the children whose deaths you had observed were
3
in fact dying in large numbers between the hours of
4
1:00 a.m. and 5:00 a.m. on the cardiology wards?
5

6 A. I recollect that some time, I
7 can't remember whether it was the end of August or
8 during or subsequent to the meetings with the nurses,
9 that we were informed these children were dying in the
10 evening hours after the routine working day. So, I
11 can't remember exactly when that first came to my
knowledge, whether it was August or September.

12 Q. When it did come to your knowledge
13 whether it was in August or September, was it a factor
14 upon which you placed any significance, Dr. Freedom?

15 A. Yes, I think we were concerned
16 that perhaps if there was a relative shortage of
17 nurses at night, that perhaps closer monitoring of the
children might make some bearing.

18 Q. Was it your impression also at
19 the time, Doctor, that there was a shortage of nurses
20 for night duty?

21 A. Yes.

22 Q. And when did you form that
impression?

23 A. I think we talked about that in
24 September at one of the meetings with the nurses.
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Q. Did you have the experience at any point with any of these patients that we have discussed so far Doctor of during the summer of wishing to designate constant care or shared care duties only to find that there was an insufficient quota of nurses available to meet that need?

A. I don't recollect a specific case. Again, the staff physicians rarely write orders on the chart. We would suggest that a child be given very close care and I would assume that the nursing service who shares the same concern as we do of patients would do everything they could to accommodate it. I think that during the summer and the fall of 1980 it was known in the City there was a shortage of nurses and one had to make do.

Q. Was that a shortage which you felt, Dr. Freedom, was generally perceived amongst the cardiologists at the hospital that summer?

A. Yes, I do.

Q. Had any member of the nursing staff raised with you the need for increased nursing numbers at night, a higher nurse/patient ratio?

A. I can't recollect that they came directly to me and brought that up. Dr. Fowler was the Clinical Chief of Cardiology and I would think perhaps they might have felt it more appropriate to go



Freedom, dr.ex.
(Cronk)

CC 4

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2 to Dr. Fowler as the Clinical Chief.

3

4 did any member of the nursing staff or nursing
5 administration approach Dr. Fowler on that kind of
6 an issue during the summer of 1980?

7

A. I don't know.

8

Q. Doctor, let's take for a moment
the case of Dion Shrum.

9

A. Yes.

10

Q. And the issue of the notation in
the progress notes or in the record for constant care
or shared care nursing duties. You have told us
earlier today that in your view following the catheter
study on Dion Shrum it was advisable that he be
admitted to the ICU and that after discussions I take
it with an intensivist from the ICU it was determined
that he should stay on the ward and was not admitted
to the ICU?

11

A. Correct.

12

Q. Having regard to your concern, or
at least initial concern that the child should be
admitted to the ICU, Doctor, were you also concerned
that he receive as high a level of nursing care on the
wards as was possible given that he could not or was
not going to be admitted to the ICU?

13

A. Yes.

14



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CC 5

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Q. Was that the kind of situation,

3

Dr. Freedom, when you would have been inclined as
the attending physician to direct or request constant
nursing care or shared nursing care duties?

4

A. Again, I think I would leave it
somewhat to interplay between physicians and nursing.
I think that most of the time the nurses were very
capable and conscientious up there and would share
the same concerns we were and certainly as one reads
their own notes about Dion Shrum, I think they would
also address the issue with closer nursing obser-
vations if such nurses were available.

5

Q. If you had a concern, Dr. Freedom,
that the condition of a patient like Dion Shrum was
sufficiently grave that increased monitoring, or at
least closer monitoring of the kind available in the
ICU would be a desirable end, would you not have been
concerned to express to the nursing staff and to the
other cardiologists involved on the floor your concern
that a higher level, or at least the highest level of
monitoring as was available on the ward be provided
to the child?

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A. The answer to that is yes and if
you are referring to Dion Shrum, I am sure that was
communicated because all of us, Dr. Schaffer, myself,
we all had concerns about this child. The ICU people



CC 6

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2 came up and when they said that they didn't feel the
3 child should go down, I am sure that put a burden on
4 the floor.

5 Q. Do you recall, Doctor, having
6 specifically requested or directed that this child
7 receive constant care or shared care nursing
8 attention?

9 A. I don't think in the 15 years
10 since I have graduated from medical school I have
11 ever used the word 'shared care'. I would address it
12 as to closer observation.

13 Q. All right. Do you recall having
14 done that in the case of Dion Shrum?

15 A. Yes.

16 Q. Can you help me, Doctor --

17 THE COMMISSIONER: I am sorry, before
18 you go on. We have heard that term used. It is not
19 an official term I take it, shared care. Constant
20 care seems to be one nurse who is in constant
21 attendance except when she is relieved for some
22 reason; shared would be I take it two nurses. That's
23 what I had understood. You don't recognize those
24 terms?



1

CC-3-1

2 THE WITNESS: Well, I recognize them
3 now, but when I was in Boston as a house officer there
4 wasn't an intensive care unit.

5

THE COMMISSIONER: No, no, I am really
6 referring to Sick Children's Hospital.

7

THE WITNESS: Well, what I'm saying
8 is that my own perception I would ask for observations
9 every 15 minutes and if a nurse needed to share care
10 or if they could allot one nurse, that didn't matter
11 to me as long as that child had routine observations
every 15 minutes.

12

So, I don't use the term 'shared' or
13 'constant'. I would rather direct it to how often
I would think an individual child needs to have vital
14 signs monitored.

15

MS. CRONK: I understand, Doctor.

16

With respect to the description of nurse/patient care
17 as constant care nursing or shared care duties, we
have on occasion in our course through these various
18 charts seen a notation or a direction of that kind
from other cardiologists or residents involved on the
20 floor or a notation by a nurse in the progress notes
21 that that was the situation for a particular child?

22

A. Yes.

23

Q. Do I understand your evidence

24

25



Freedon, dr.ex.
(Cronk)

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CC-3-2 2 to be that at least in your own experience that was
3 (a) unusual for you to do, you do not direct constant
4 care or shared care nursing duties on the record of
5 the chart and (b) to the best of your understanding
6 was that an unusual direction to be written directly
7 in the record by a staff cardiologist or a resident
involved in the care of a patient?

8 A. Well, let me address both parts
9 of that. Certainly the residents will address
10 constant care transfer to ICU, vital signs every few
11 minutes. It is very unusual for a staff cardiologist
12 or most staff physicians to write orders in a
hospital chart.

13 Q. Doctor, with respect to the
14 ordering of closer observations, I took you to mean
15 the closer monitoring of vital signs. Is that
16 correct?

17 A. Yes.

18 Q. If you were to make an order
19 of that kind in respect of any of your patients or
20 patients with whom you were directly involved, is
21 that the kind of order that you would direct a
resident to record on the record of the child?

22 A. Correct.

23 Q. Can you help me, Doctor

24

25



1

CC-3-32 Freedom, and I frankly say that I have examined the
3 record of Dion Shrum and I have been unable to locate
4 a notation for constant care nursing or shared care
5 nursing. Is it your recollection that vital signs
6 were ordered to be taken as you have suggested very
7 frequently after the child was returned to the ward
from the catheter laboratory?

8

A. Yes.

9

Q. And is there an indication in
10 the record of that, to the best of your knowledge,
11 Doctor?

12

A. You would have to hand me
again Dion Shrum's chart.

13

Q. Doctor, we will be taking the
14 afternoon break in a few moments, perhaps I could
15 ask you to briefly look at it over the break.

16

A. Fine.

17

Q. Returning then to the events,
18 if I may, of July and August and the observations and
impressions that you were forming as to the increased
19 number of deaths that had been occurring on the wards.
20 Did you, Dr. Freedom, at the end of August of 1980
21 form any impression as to whether the deaths were
22 occurring on the cardiology wards at the time that any
23 particular nursing team or nurse were assigned to the

24

25



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Freedom dr.ex.
(Cronk)

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CC-3-4 2 ward for duty?

3 A. No, I had no recollection
4 there was an individual nursing team or nurse problem
5 per se.

6 Q. Was that a matter, to the best
7 of your recollection, that was raised with you or to
8 your knowledge with other staff cardiologists by any
9 of the residents or by any member of the nursing staff?

10 A. No.

11 Q. Thank you.

12 Mr. Commissioner, I am about to move
13 to a specific child, Brian Gage.

14 THE COMMISSIONER: Yes, all right.
15 Could we make it just 10 minutes because I want to
16 close right off on time, perhaps 5 minutes earlier,
17 I have another meeting I seem to have gotten involved
18 in.

19 MS. CRONK: Thank you, Mr. Commissioner.

20 THE COMMISSIONER: We will take 10
21 minutes then.

22 --- short recess

23

24

25



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CC-3-5 2 --- upon resuming.

3 THE COMMISSIONER: Yes, Ms. Cronk?

4 MR. CRONK Q: Dr. Freedom, over the
5 break did you have an opportunity as I did to review
6 the chart of Dion Shrum?

7 A. Yes, I did. First of all,
8 as I look at this chart again, Ms. Cronk, I would be
concerned that an order page may be missing.

9 Q. Well too ---

10 A. Well, let me go on. However,
11 on page, I believe it is the last page in my chart,
12 00060, as one looks at the nursing charting you will
13 see there are 99. They start off at 2300 and then
14 02, 04, 06, every couple of hours. You will see,
15 however, that - and it takes us that way until 1200
16 midday. There is then a break, and I presume that
17 is the time they are getting ready to take this
18 youngster to the catheter laboratory and that child
got to the lab at 1330, I believe the nurses said.

19 However, starting at 1600 I see vital
20 signs recorded 1600, 1615, 1630, 1645, and again for
21 them to take blood pressures on sick little babies
22 it takes time. So, I would consider every 15
23 minutes to be very rapid vital signs, whether it is
shared care or constant care.

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CC 3.6
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Q. Well, just dealing with that, Doctor, if I may. You have raised the suggestion that perhaps one of the doctor's order sheets is missing from the chart?

A. Yes.

Q. And we will certainly check the original copy of the chart, and perhaps you can check your own records. The only doctor's record page that is presently contained in the chart is found at pages 53 and 54 and based on my review of those orders there does not appear to be any indication as to the frequency with which vital signs are to be taken. Is that correct?

A. Yes, I would certainly agree.

Again though I would be concerned that the top of page 54, we see 0240, which is two in the morning, two hours after the baby was admitted, and I can see the last order in the chart is NPO. I presume that was written when we had decided to move up the timing of the catheter study, you know, to Saturday afternoon as opposed to Sunday or Monday. So, I would be very concerned that we are missing the next page and usually right after a catheter study there are a series of orders above vital signs.

Q. Well, again, Doctor, accepting that there may be a page missing, and we will both



CC 3.7

1
2 check that, on the basis of the pages that are
3 presently in the record, I take it you would agree
4 with me that there is no indication as to the
5 frequency at which vital signs are taken?

6 A. No, I disagree entirely.

7 Q. On pages 53 or 54, Doctor?

8 A. No, I think the better evidence,
9 Ms. Cronk, is on the last page of the chart.

10 Q. All right. Well, dealing with
11 the flow sheet that appears at page 60, Doctor, and
12 again recognizing that you have suggested that there
13 may be a page of the flow sheet missing, I note that
14 the early entries for the taking of vital signs, or
15 at least the times at which they are recorded, do not
16 appear to be at 15 minute intervals, but fairly as
17 you have pointed out, from 1600 through to at least
18 1700 they do appear to have been taken at 15 minute
19 intervals and then after that once again they are
20 every half hour. So that at least on the basis of
21 page 60 of the flow sheet there is some inconsistency
22 in terms of frequency with which they are taken but
23 for a block of that period they are taken as
24 frequently as every 15 minutes. Is that fair,
25 Doctor?

26 A. I am not sure I would use the
27 word 'inconsistency'. I would say it would be helpful



C 3.8

1
2 if there was another page we would have it. I think
3 the more important consideration, as we both look at
4 this chart, is what was done. As I look at it,
5 something made the nurses, who take the vital signs
6 every 15 minutes and, again, whether that was on their
7 own discretion, and the nurses on the floor are very
8 good, but I would presume that was in conference with
9 us, they knew the ICU was up there and that there was
some decision made.

10 Also on page 41 where there is a
11 nursing note, and I can't read the last name, but a
12 third of the way down the page where it says 1630
13 to 1845 it says that they wanted, half way in that
14 paragraph Dr. Goldman had called Dr. O'Toole and he
15 examined the baby and ordered the baby be monitored
very closely.

16 Q. All right.

17 A. So, I would agree with you that
18 I do not see it written in an order sheet but the
19 nurses have perceived that and they've done that.

20 Q. And we will look, Doctor, to see
21 if there is a second page of the flow sheet or a
22 second page of the doctor's orders that appear to be
missing from the chart. Thank you.

23 Doctor, Mr. Lamek reminds me on page 60
24 of the flow sheet that is in the chart, the last page
25



Freedom, dr.ex.
(Cronk)

CC 3.9

1
2 of the chart.

3 A. Yes.

4 Q. You'll see from 1700 when the
5 vital signs are reported, the next entry is 1730,
6 half an hour later, and similarly half an hour
7 later at 1800. Was there a decision taken, of which
8 you are aware, Doctor, to reduce the frequency of
9 vital sign readings from 15 minutes to 30 minutes
at that stage?

10 A. No. As a matter of fact, as I
11 look at this, I would be concerned because the baby's
12 blood pressure was now 60, 60 over pulse, and on
13 admission it had been 95 to 100. So, I don't think
14 anyone would have consciously ordered it reduced.

15 Q. And one would have thought,
16 indeed as was later specifically indicated by
17 Dr. O'Toole, that the baby should be monitored very
18 closely, particularly because of those kinds of
changes?

19 A. Correct.

20 Q. But that doesn't appear to have
21 happened on the basis of that particular flow sheet?

22 A. Correct. They are certainly
23 alternating, at least at that time, between 15
24 minutes and I certainly agree with you every 30 for
that next hour.

25



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CC 3.10

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Q. Thank you, Doctor.

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Doctor, the next child to which I draw your attention who died on the ward was Brian Gage who died on September 25th, 1980. That medical record, Mr. Commissioner, is Exhibit 61 of these proceedings.

We know Doctor from previous evidence that this child was admitted on September 5th, 1980. As I understand it, you apparently saw him on the day of his admission, examined him and prepared a consultation note concerning your examination, is that correct?

A. Yes.

Q. If we turn to page 67 of the record, Doctor, I take that to be a written consultation note concerning that examination?

MR. ORTVED: What page?

MS. CRONK: Page 67.

THE WITNESS: Correct.

MS. CRONK: Q. And you described or noted that the child at the time of that examination, Doctor, to be "small, tachypneic, cyanotic baby" - is that next word "not"?

A. No, "mod.".

Q. Right.

A. "moderately dyspneic not



Freedom, dr.ex.
(Cronk)

1

CC 3.11 2 severely distressed".

3 Q. And your impression is recorded
4 on the right-hand side of the bottom of the
5 consultation note, Doctor. Perhaps you can help me.

6 At the time that there was a transposition of
7 the great arteries suspected with an intact
8 ventricular septum with inadequate atrial mixing --
is the next word metabolic acidosis?

9 A. Yes.

10 Q. And you indicate further that he
11 would be scheduled for catheterization that night?

12 A. Correct.

13 Q. Did the catheterization proceed
14 that evening, Doctor?

15 A. Yes.

16 Q. And as well, as I understand it,
17 a two dimensional echocardiogram had been conducted
18 and as well an electrocardiogram and a chest X-ray
all on September 5th, the date of his admission?

19 A. Correct.

20 Q. Can you briefly outline for us,
21 Doctor, the findings made as a result of the
22 catheter procedure?

23 A. Well, I think one the things that
24 happened was that when they placed the baby on the
catheter table, again, I wasn't in charge of the

25



CC 3.12

1

catheterization, it was one of my former colleagues,
Dr. Walter Duncan, the child had a respiratory
arrest with a slow heart beat and needed to be
resuscitated. They then went ahead and completed
the catheter study and did the so-called balloon
septostomy.

7

Q. And that episode of respiratory
arrest occurred, as I understand it, immediately
before the catheter procedure was undertaken?

10

A. Correct.

11

Q. All right. And he was
resuscitated with medical intervention at that time
or spontaneous?

13

A. A little bit of both.

14

Q. Meaning there was medical
intervention of some kind at the time?

16

A. Yes.

17

Q. And as I understand it, Doctor,
to briefly summarize the course of the child over
the next two weeks or so, he was sent to the neonatal
ward after the catheter study where he was prescribed
and administered digoxin?

21

A. Correct.

22

Q. Digitalized, maintenance digoxin
was prescribed thereafter along with prostaglandin
to assist with ensuring that the ductus remained

25



Freedom, dr.ex.
(Cronk)

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CC 3.13

2

open?

3

A. Correct.

4

5

Q. But he remained in heart

6

failure, as I understand it, was losing weight and
continued to have an enlarged liver?

7

A. Correct.

8

Q. The child was subsequently
scheduled for surgery on the 25th of September?

9

A. Correct.

10

11

Q. Did that surgery in fact take

place?

12

A. No, it did not.

13

14

Q. Indeed, the night before, as I
understand it from the record, that is, on September
24th, according to the progress notes, he appeared
not to be in respiratory distress, vital signs were
stable, colour was pale and he was not cyanosed. Is
that consistent with your understanding of the
child's condition?

15

16

A. No.

17

18

Q. All right.

19

20

A. It's not. On September 24th

21

22

they recorded a blood gas analysis with a PCO₂ of
55 and for a baby who was breathing very fast in the
50's that is retaining carbon dioxide and it is
certainly quite worrisome.

23

24

25



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Freedom, dr.ex.
(Cronk)

5314

CC 3.14

1
2 Q. All right. Doctor, could you
3 turn with me to page 65 of the record. Do you see
4 the nursing note for September 24th starting in the
5 middle to the end of the page, page 65?
6

A. Yes.

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6 sept 83 2 Q. In that nursing note it is
DD 3 recorded that the patient was in no respiratory
EMTra 4 distress, vital signs were stable; his colour was
5 pale but he was not cyanosed. He vomited a feeding
6 and I gather there were two successive attempts to
7 again feed the child. He vomited three times and the
nurse sat him up to burp him gently. He was alert.
8 He was in no respiratory distress and she continues,
9 his apex fell to 49 and weak. CPR was initiated and
10 Code 25 was called.

11 Now, on the basis of the earlier
12 description of his condition on that evening, doctor,
13 I take it that you have some difficulty in considering
14 the child's condition to be stable at that point
15 notwithstanding the description we find contained
in the progress notes?

16 A. Yes. I think there is a
17 discrepancy between how the nursing perceived this
18 baby and how I think the physicians perceived this
19 baby, considering he was scheduled on the following
20 day to have a surgical opening made to make him
pinker because he was so blue.

21 Q. All right.

22 And indeed if we turn to the
23 arrest note, doctor, that appears on page 64, the
24

25



Freedom
dr.ex. (Cronk)

1

DD2 2 previous page of the progress note --

3 A. Yes.

4 Q. -- we see the doctor's
5 indication that he was called to see the patient
6 because of - I take that to be sudden cardio-
7 respiratory arrest?

8 A. Correct.

9 Q. Apparently he had been
10 vomiting tonight and had respiratory distress today.

11 A. Yes.

12 Q. During a feed, and I have
13 difficulty reading --

14 A. I would say a clear fluid.

15 Q. He suddenly arrested.

16 A. Right.

17 Q. Doctor, is your understanding
18 and familiarity with the condition of this child
19 sufficient so as to permit you to express an opinion
20 as to whether or not the arrest itself and the
21 terminal events experienced by this child and the
22 onset of the terminal events were in fact sudden in
23 your judgment as has been suggested in the arrest
24 note?

25 A. Again I didn't care for this
baby myself during the latter part of his stay.



DD3

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As I reviewed the chart I would be concerned that this baby was not doing well right from the word go; had had problems with kidneys. Had blood in his urine on September 17th. Heart failure with a loud gallop noted on September 17th.

Two days later had a 5 centimetre liver with edema, with swelling around his eyes.

On the 24th retaining carbon dioxide. So I would think that although the term "sudden" was used, I think this baby was very ill, was scheduled for an operation which carries modest risk, but because he was blue and had a heart failure, so I would think that the sequence of events are consistent with a very sick baby with transposition.

Q. Doctor, you have told us that surgery was scheduled for September 25th, the next day.

A. Yes.

Q. Would I be correct in assuming that the proposed and scheduled surgery for this child would have been a matter of discussion at the cardiology conference held the morning of the 24th?

A. I think you would have to refresh my memory, Miss Cronk, what the 24th was. Was it a Monday?



Freedom
dr.ex. (Cronk)

1
DD4

2 Q. That I don't know, doctor.

3 It was a day before the scheduled surgery.

4 A. No. I would say that the
5 form in the morning conferences is not invariably
6 to discuss plans that have been made for the children
7 already on the floor in the sense that this decision
8 was taken by the Ward Chief, the people on the floor,
in concert with the surgeons.

9 If it had already been scheduled
10 I am not sure that they would bring it up again in
11 the morning conference.

12 Q. Do you know, doctor, when
13 the surgery was scheduled?

14 A. I know it was scheduled for
the following day.

15 Q. Do you know when the decision
16 was made that he would go to the OR on the 25th?

17 A. Yes. I remember seeing a
18 note in the chart.

19 Q. To assist you in that regard,
20 doctor, the progress notes for the 24th of September,
21 on page 61 and the preceding day's suggest that he
22 was a candidate for and was awaiting surgery on the
ward.

23 A. Correct.

24

25



Freedom
dr.ex. (Cronk)

1
DD5 2 Q. Do I correctly take it then
3 that it was a matter of slotting the child in for
4 surgical operation?

5 A. Correct. I think also there
6 had been concern about this baby's kidney function
7 and I think that we would be concerned about doing
8 surgery in a baby whose kidney function had been sub-
optimum.

9 Q. Doctor, on the basis of your
10 familiarity with the child's condition and the con-
11 cern with respect to kidney function you have just
12 outlined, can you help me as to whether or not there
13 was any reason to suspect or to apprehend on the 24th
14 that the child might not live long enough to reach
15 surgery on the 25th?

16 A. Oh, I think if we had known
17 that we would have operated on the 24th.

18 Q. It was expected that the
19 child would live long enough for the surgery to take
place?

20 A. Yes.

21 Q. Doctor, at the time of the
22 cardiac arrest of Brian Gage, at the time of his
23 terminal events, were you contacted and did you attend
24 on the ward at the time?

25



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Freedom
dr.ex. (Cronk)

5320

DD6

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A. No, I did not attend at the time of the baby's arrest.

4

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Q. Did you attend at the gross autopsy on the morning following his death?

6

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A. I remembered seeing his heart. I can't remember the timeframe, whether it was that day. I would assume at the time of the autopsy or later that day when he was finished. But I do remember looking at the baby's heart.

10

Q. You did see the baby's heart?

11

A. Correct.

12

13

14

Q. And I take it, doctor, that you subsequently report to the referring physician concerning the progress of the child and ultimately his unfortunate death?

15

A. Yes.

16

Q. If we could turn to page 13.

17

A. Correct.

18

19

Q. Is that your reporting letter to the referring physician?

20

A. Yes.

21

22

23

Q. And you describe, doctor, the condition of the child in the second paragraph of that letter and you indicate that right before the catheter study as you previously indicated the child

24

25



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DD7

2 experienced respiratory distress which you describe
3 in the reporting letter as having become extremely
4 hypoxic and he nearly sustained a cardiac arrest.

5 He was improved, you record, by a
6 balloon septostomy, but his progress is quite slow.

7 You go on to report upon the
8 results of the catheter procedure and his condition
just prior to death.

9 You then state:

10 "It is unclear as to the precise
11 cause of death, but most likely it
12 was due to a hypoxic episode."

13 A. Right.

14 Q. Do I correctly take it at
the time of reporting to the referring physician,
15 Dr. Freedom, you were in some doubt as to the explana-
16 tion or cause of this child's death?

17 A. I think what I was trying to
do, Miss Cronk, was to sort of relate the gestalt to
the people on the floor of a baby whose course was
somewhat unusual in that we don't -- we see a lot of
transposition babies each year but we see a relatively
few with renal failure who are progressing so poorly
with such profound heart failure.

18 So I think in that paragraph I tried

19

20

21



Freedom
dr.ex. (Cronk)

1 DD8 2 to give a little bit of this dilemma.

3 Then in the third paragraph I try
4 to make it clearer.

5 Q. In the third paragraph,
6 doctor, you refer to the autopsy results for this
7 child. I take it again you are referring to the
gross autopsy given the date of the letter?

8 A. Correct.

9 Q. Was it your view that the
10 early gross post mortem findings supported the ex-
11 planation of an hypoxic episode as the likely cause
12 of death?

13 A. Correct.

14 Q. What were the findings particu-
15 larly do you recall from noting the heart and the findings
16 of the Pathology Department at gross autopsy which
suggested that to you?

17 A. That the communication between
18 the baby's two atria which had been made by the
19 balloon septostomy was small and inadequate to sustain
20 a reasonable level of oxygenation.

21 Q. Doctor, in the normal course
22 of events if a child in this condition were to be
23 experiencing hypoxia or an episode of hypoxia, would
24 you expect some change in his respiratory status to be
25



1
DD9 2 manifested in a physical fashion?

3 A. I think babies' respiratory
4 rates will vary with or without changing levels of
5 blood oxygen levels.

6 Q. In the case of a situation
7 where a child is felt to be hypoxic, however, to be
8 suffering from lack of oxygen --

9 A. Yes.

10 Q. -- in your experience would
11 it be common for that to be accompanied by a physical
12 manifestation of that in changes in the respiratory
13 status of the child?

14 A. Yes, I think that is
15 appropriate.

16 Q. In summary, doctor, would you
17 expect some indication of cyanosis, be it slight or
18 moderate, in a child that was experiencing hypoxia
19 in the bloodstream?

20 A. For an infant to be cyanotic
21 one needs to have at least 5 grams of reduced hemo-
22 globin in the bloodstream. So one can take the
23 bluest baby who is severely cyanosed to all of us in
24 this room, and if the baby becomes relatively anaemic,
25 that is through blood tests, through chronic illness,
the level of cyanosis will not be as apparent purely



1

DD10 2 because there is relatively less blood that the
3 baby is carrying around.

4

5 correlation between what you might expect from an
6 oxygen level and how blue the baby is.

7

8 Q. Right. But having regard
9 to the respiratory status of the child you would
10 in the common course expect some indication, although
you would not necessarily expect some indication of
cyanosis?

11

A. Correct.

12

13 Q. And we know, doctor, at
least from the progress notes, bearing in mind your
evidence as to the severity of the child's condition,
14 that immediately prior to its death its respiratory
15 status was described as stable with no distress. Is
16 that correct, doctor?

17

18 A. Again on the third line --
excuse me, the second line after nursing notes it
says "colour was pale but not cyanosed".

19

20 I think it is not uncommon to see
a baby and describe him as pale. As a matter of fact
21 most parents even when they know a baby is blue they
will not call him blue. They will call him pale because
22 of the slate grey colour that many of these babies have.
23

24

25



1

DD11 2 So on that one note, you know, where
3 it says no respiratory distress, I take it for what it
4 says. But I note the same day that the baby was
5 retaining carbon dioxide at 55, so to me that cannot
6 mean that this baby was comfortable and stable.

7 Q. In directing your attention
8 specifically to respiratory changes as opposed to
9 the colour of the child, doctor, am I correct that
10 immediately prior to the episode which led to his
11 death it appeared that his respiratory condition was
stable at that point?

12 A. Well, again on page 62 --

13 Q. You are referring to the
progress notes?

14 A. I am referring to a nursing
note.

16 Q. Yes.

17 A. They describe the baby's
respiratory rate between 76 and 62.

19 Q. Yes.

20 A. And that is very fast for a --
I am sure it is much faster than for a normal baby,
21 and to me again that would be commensurate and
22 comptatible with a baby that is working hard, that
23 is breathing too fast, and perhaps one that is going to

24

25



1
2 DD12 tire out.

3 Q. Perhaps, doctor, I was
4 directing my attention to page 65 of the progress
5 notes --

6 A. Right.

7 Q. -- where the nursing note
8 indicates that the patient was in no respiratory
9 distress and the vital signs were stable. Again a
notation that the child was pale.

10 There is some inconsistency it would
11 appear between those two.

12 A. Well, I wouldn't use the
13 word, Miss Cronk, "inconsistency". I think babies
14 change a lot. I have told many parents over the years
15 that when they come into a hospital and they speak to
16 five doctors and nurses during the course of twelve
17 hours they are going to wonder if they are talking
about the same patient.

18 Q. The first note, however,
19 doctor, appears to be in the morning of the 24th.

20 A. Well, it says 0715 to 1915.
21 So that is a long morning.

22 Q. So it is hard to say when
23 the condition was noted as having respiratory
24 difficulty of that kind?

25



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DD13

A. Right.

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Q. Do I take it correctly then,

doctor, that in your opinion both the clinical symptoms exhibited by this child prior to death and the post mortem findings at least at gross autopsy were supportive and indicative of an hypoxic episode as the likely cause of death?

A. Yes.

Q. We know, doctor, that during the course of this child's stay in the Hospital digoxin was both prescribed and administered and we know from prior evidence that on September 24th, the day preceding the child's death, the digoxin level was obtained with a reading as I recall it of 3.5 nanograms per millilitre.

A. Correct.

Q. Were you aware of that digoxin level reading on this child?

A. Again I wasn't aware of it at the time as I wasn't the Ward Chief, but I am aware of it now.

Q. At the time of preparing your reporting letter to the referring physician were you not informed of the digoxin level, doctor?

A. I may have been informed but



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DD142 I wasn't particularly concerned by it.

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Q. The 3.5 level on the day

prior to his death, however, as I understood your earlier evidence would be slightly higher than what you would consider to be the normal therapeutic range for digoxin?

A. Correct.

Q. And you have indicated as well earlier, doctor, that in your view there was some evidence of kidney failure in this child?

A. Yes, early on.

Q. Did that in your view play any part in the cause of his death, his arrest?

A. I would think again in a baby that has multisystem disease, that his kidneys retain carbon dioxide, hypoxia, that these are usually additive in terms of management of the baby and the likelihood of the baby not doing well.

It is my recollection as well, though, that although this level was recorded on the 24th as 3.5, it was held -- excuse me, no more digoxin was given and he died 24 hours after that level came back.

Q. That is my understanding as well, doctor, but apart from the digoxin level that



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5329

1
DD15 2 was recorded on the 24th of September, dealing with
3 the issue of kidney failure or suspected kidney
4 impairment --

5 A. Yes.

6 Q. -- would you turn with me
7 to the biochemistry report in respect to Brian Gage
commencing at page 117.

8 A. Yes.

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Q. September 7th? If we examine the BUN levels and the creatinine levels for the next several days, Dr. Freedom, dealing first with the creatinine levels on the 8th of September at page 118 we see a reading of 3.2; another reading on September the 8th, 1.8.

A. Yes.

Q. Reading on September 10th at page 119 of 1.2.

A. Yes.

Q. A reading on September 11th of less than .4?

A. Yes.

Q. On September 12th a sample was taken and there was apparently insufficient quantity in the sample to conduct an assay.

Moving to September 17th for the next recorded reading we find a 2.2, and again on September the 18th there appears to have been a sample of insufficient quantity taken for assay. So the last reading we have as to a creatinine level was 2.2 on September 17th several days prior to the child's death?

A. Correct.

Q. Would you agree with me, Doctor,



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that at that point, that is September 24th, the day before his death, we don't know what his creatinine level was, but on the days preceding that, from Setpember 8th through to September 17th at least it appeared to have been reduced from the high of 3.2 earlier recorded on assay?

A. Correct.

Q . And similarly if we examine the other BUN levels - I won't take you through all of them, Doctor - but they are as well recorded in the biochemistry reports, and as I review these readings, the highest reading obtained was 21 on September 8th.

Would that be a level of sufficient height to be of concern to you, Doctor?

A. Yes, it would.

BUN in babies, especially newborns, there is not infrequently a discrepancy between the creatinine and BUN.

In an adult, for instance, who has a reasonable protein diet with impaired renal function, both levels can be very high, but in an infant who is not getting a lot of protein the BUN reflects the dietary intake. So one can see a baby with an elevated creatinine but where the BUN would not be commensurate



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Freedom, dr.ex.
(Cronk)

5332

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2 solely because the baby is not getting enough
3 protein.

4 Q. All right.

5 A. So I would say for a baby that
6 is this ill who is not getting a normal diet that the
7 BUN was certainly abnormal and in a way may be even
more significant because his protein intake is low.

8 Q. I am sorry, a BUN level of
9 21 as was recorded at the beginning of September?

10 A. Correct.

11 Q. If we follow through the
12 biochemistry report levels recorded for BUN levels,
13 Doctor, we see that the level on the 9th of September
was 19.

14 A. Excuse me, what page are you
15 on?

16 Q. On September the 8th. I
17 am looking at page --

18 A. 118?

19 Q. 118.

20 A. Okay.

21 Q. Then looking at September 9th
down to 19.

22 A. Okay.

23 Q. It progresses on September
24 10th down to 11th. September 11th down to 7.

25



1

2 September 12th down to 6.

3 A. Yes.

4 Q. September 16th back up to 11.

5 A. Yes.

6 Q. September 17th is 8. September
7 18th it is 8. September 19th and 21 it is 11, and
8 on the 22nd, 23rd and 24th it is at 14, 15 and finally
9 16 on the day prior to death.

10 A. Right.

11 Q. Is a level of 16 a concern to
you in a patient with this kind of condition, Doctor?

12 A. I would say that although the
13 number is within the upper normal range, I would have
14 to know exactly what protein intake the baby was
taking in order to judge it.

15 For instance, if this baby had virtually
16 no protein I would have more concern about that level
17 although it is not terribly high I would agree with
18 you, Miss Cronk.

19 Q. And, Doctor, if the child
20 was experiencing malfunction, if you will, of the
21 kidney, would you expect to see some evidence of that
22 both in the creatinine levels and in the BUN as
recorded?

23 A. I think we have.

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We have certainly seen creatinine elevation. They found blood in the baby's urine on the 17th of September, and with the fluctuating BUN I think there is ample evidence of a concern that this child's kidney function was not normal.

Q. And given that there is no

clear indication in the medical record as to what the creatinine level was in the days immediately preceding death and that the BUN level appeared to be at 16 having been up and down again, are those the findings in the record which lead you to suggest that there was evidence of kidney failure in this child?

A. Yes. Well, I would use the word kidney dysfunction. I think the baby was always making urine or at least in my review of the charts, so they certainly hadn't stopped, but they were certainly impaired in their function.

Q. Doctor, having seen the heart at the gross autopsy of Brian Gage, did you subsequently or were you subsequently provided with a copy of the final autopsy report?

A. I think I was.

Q. Did any of the results disclosed or reported upon in the final autopsy report influence



Freedom, dr.ex.
(Cronk)

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2 you to change or alter the opinion you had previously
3 reached as to the likely cause of death of this
4 child?

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A. No.

6 Q. Doctor, do you recall at the
7 morning cardiology conferences at which the death of
8 this child was discussed at subsequent meetings of the
9 cardiology department, do you recall any suggestion
10 having been raised by any member of the medical staff
11 or the nursing staff as to the possibility of digoxin
12 intoxication as a contributing factor to this
13 child's death?

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A. No.

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EE.1
2 Q. Doctor, we have heard evidence
DM/ko
3 both as to the morbidity and mortality meeting which
4 occurred on September 5th.

5 A. Yes.

6 Q. And we have heard evidence about
7 the second morbidity and mortality meeting which
8 occurred on September 26th, 1980.

9 A. Yes.

10 Q. Did you attend either or both of
those meetings?

11 A. I think I attended both.

12 Q. Dealing if we could first then,
13 Dr. Freedom, with the meeting which was held on
14 September 5th. Perhaps Mr. Registrar the Doctor
15 could be shown Exhibit 45, which is a copy of the
minutes of the meeting held on September 5th.

16 While the Registrar is getting that
17 exhibit Dr. Freedom, have you had occasion in the
18 past to review the minutes from that meeting?

19 A. I don't remember that I have, I
20 have reviewed a lot of material, maybe when I see it.

21 Q. Perhaps looking at it will --

22 A. Will bring back memories. I
23 think I have seen it before but it has not been
recent.

24 Q. In looking at the minutes Doctor,

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EE 2 2 you are content that you were one of the staff
3 3 cardiologists that was present at that meeting?

4 A. Yes.

5 Q. Doctor, what did you understand
6 5 the intended purpose of the meeting to be?

7 A. Drs. Rowe, Dr. Rowe had asked
8 7 Dr. Jedeikin to organize this conference in response
9 I believe to nursing concerns about the number of
10 9 deaths that were had on the floor during the latter
11 10 part of the summer. There was, at least it was my
12 11 impression that the nurses had the concern, what had
13 12 we been doing, could we do something more.

14 Q. You told me Doctor that as at
15 13 the end of August of 1980, some week, five days prior
16 14 to the holding of this meeting, that to the best of
17 15 your recollection no member of the nursing staff had
18 16 approached you, save for the discussions that you
19 17 think may have taken place at the end of August, or
20 18 at the time of this meeting, with respect to the
21 19 number of deaths that were taking place on the ward.

22 To the best of your recollection, was
23 20 there any concern expressed by members of the nursing
24 21 staff, which resulted in this meeting, or which
25 22 triggered this meeting, other than the issue of the
23 23 adequacy of the care that was being provided?

24 A. No.

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EE 3 Q. Doctor, did you prepare any
notes in preparation for this meeting?

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A. No.

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Q. To the best of your recollection
what was your role intended to be at the meeting, why
were you there?

7

A. I believe Dr. Jedeikin had asked
me to bring to the meeting as much of the pathology
information as we could on those children that had
been autopsied.

11

Q. And I take it you did so?

12

A. Correct.

13

Q. Did you keep any notes at the
meeting?

14

A. No.

15

Q. Doctor, you will recall that we
discussed the number of deaths which had occurred as
at the end of August on the wards, that were 11, and
with the death of Brian Gage that we have just
discussed that number was up to 12 by the time this
first mortality and morbidity meeting was held on
September 5th. Can you help me Doctor, did you
participate in the selection of the cases that were
to be discussed at that meeting?

23

A. No.

24

Q. Do you have any knowledge or

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EE 4

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2 understanding as to the basis upon which these three
3 particular cases were selected, being that of the
4 Bilodeau child, Turner and Taylor?

5 A. No.

6 Q. Can you help me Doctor as to
7 whether or not the case of Brian Gage was discussed
at the meeting?

8 A. No, I think - I can't remember
9 specifically other than having these minutes before
10 me, and the name is not there, and I presume it wasn't
11 reviewed at that meeting.

12 Q. I am sorry Doctor, fairly, Brian
13 Gage died after the date of the first meeting and
14 prior to the second meeting. It was Laurette Heyworth
15 who died on September 2nd bringing the total number of
16 deaths to 12. Do you recall whether or not Laurette
17 Heyworth was discussed at the meeting?

18 A. I don't think she was discussed.

19 Q. And Doctor, if we examine the
20 minutes of the meeting, with respect first to the care
21 of the Bilodeau and the Turner babies, we have heard,
22 you have given evidence that you had no direct
23 involvement in their care and management during the
24 course of their life in the hospital, is that correct?

25 A. Correct.

Q. And I take it you are familiar by



EE 5

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2 virtue of the gross autopsy results and the pathology
3 findings which you were requested to bring to the
4 meeting, generally with their condition and the status
5 of the child prior to death, and the findings of the
6 post mortem, is that correct?
7

A. Partly. If I remember correctly
8 Ms. Cronk, Baby Bilodeau didn't have an autopsy. So
9 I would remember more clearly the children who had
autopsies.

10 Q. And that would apply to the Turner
11 child?

12 A. I would have to go back to my
13 files. I certainly know David Taylor, as we discussed
14 this morning, had an autopsy. It says here Baby Turner
15 did have an autopsy, so I presume I would have brought
that information to the meeting.

16 Q. In any event you had participated
17 in the care of David Taylor as you told us earlier?

18 A. Yes.

19 Q. Doctor, prior to attending this
20 meeting on September 5th, during your tenure at the
21 Hospital for Sick Children, that is since 1974 and
22 through to the fall of 1980, had you ever attended any
23 morbidity and mortality conferences of the kind
convened on September 5th?

24 A. In the meeting that was held, and
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EE 6

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2 I believe September 5th was a Friday, we have the
3 ongoing cardiovascular mortality conference in the
4 Department of Pathology which is held at one o'clock
5 on Mondays, to which nurses are invited, all staff is
6 invited. This one was certainly at a different time
7 than we usually have, and I think organized, as I
have indicated, for different reasons.

8 Q. This one as well Doctor was
9 particular to members, to the staff cardiologists and
10 to representatives of the nursing staff, is that
11 correct?

12 A. That is correct.

13 Q. And did not involve any cardio-
14 vascular surgeons or members of the Pathology
15 Department?

16 A. No, I don't believe it did. I
17 can't - I don't recollect whether Dr. Trusler or
18 Williams were invited to it. The three infants
19 under consideration didn't go to surgery, so I
presume they were not invited.

20 Q. In your view Doctor was the
21 holding of a meeting of this kind given the number
22 of deaths that had been observed to have occurred
23 on the wards during the summer, although an unusual
24 type of meeting, an appropriate action to be taken
25 to review those deaths?



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EE 7

2 A. Yes.

3 MS. CRONK: Mr. Commissioner, before
4 moving into the question of the meeting in detail I
5 understand and I know you have an appointment else-
6 where at 4:30.

7 THE COMMISSIONER: Yes. Well, we
8 might rise now. I want to retract something I said
9 to you in private. Namely, we might consider
10 starting early tomorrow. Because on reflection, even
11 if we do get through your examination we won't be
12 through the examination of Mr. Scott and Mr. Ortved
13 so I doubt if it will really resolve our problems.

14 Perhaps you can deal tomorrow with,
15 perhaps you can, with the children who are especially
16 represented, so that if any of those Counsel have to
17 get away can get away.

18 I think you might just as well come at
19 10 o'clock. What do you think, what is your position?

20 MS. CRONK: It is still my hope Mr.
21 Commissioner to finish the evidence in chief of Dr.
22 Freedom tomorrow.

23 THE COMMISSIONER: Even if we started
24 at 10:00?

25 MS. CRONK: It was an abundance of
26 caution which made me suggest that might not be
27 possible, and I hold that view if we start at 10:00.



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EE 8
THE COMMISSIONER: I am open to anyone's suggestion. I really don't think we will be able to, that it will do us an awful lot of good to start at 9:30 tomorrow morning. Does anybody have any particular views on it?

MR. STRATHY: Last time I suggested it I was accused by Mr. Scott of being uncivilized.

MS. CRONK: I am most reluctant that the suggestion is attributed to me then Mr. Chairman.

THE COMMISSIONER: I think we are better off starting at 10:00. It is not - speaking for the Commissioner, it is not that I am not wide awake at 9 o'clock in the morning, it is that I am always not wide awake at 4:30 in the afternoon.

MS. CRONK: Thank you Mr. Commissioner.

THE COMMISSIONER: So I think we will rise until 10 o'clock and see what happens. I was going to ask - I can assure you Doctor I was just going to ask you about your convenience too, but since we are not changing it from 10 o'clock I don't need to ask you. All right then, until 10 o'clock.

--- Whereupon the hearing was adjourned until Wednesday, September 7th, 1983 at 10:00 a.m.

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